

Asheville Medicine & Pediatrics

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed a copy of Asheville Medicine & Pediatrics
(Please print patient's name) Notice of Privacy Practices.

I consent to the disclosure of my protected health information by Asheville Medicine & Pediatrics for the purpose of providing treatment to me, obtaining payment for my health care bills, and/or to conduct health care operations.

I understand I have a right to review Asheville Medicine & Pediatrics Notice of Privacy Practices prior to signing this document. Asheville Medicine & Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by accessing the practice website, calling the office, and/or requesting a revised copy to be sent to me by mail.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Asheville Medicine & Pediatrics is not required to agree to the restrictions that I request. However, if Asheville Medicine & Pediatrics agrees to a restriction that I request, that restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Asheville Medicine & Pediatrics has taken action in reliance on this consent.

- I have read the "Notice of Privacy Practices" provided by Asheville Medicine & Pediatrics, and agree to its terms.

Signature of Patient or Responsible Party

Date