Pete Richards, DDS, PA
101A Chadwick Sq. Ct.
Hendersonville, NC 28739

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____
_____

Rights of the Patient
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to DEBBIE ANTHONY, HIPAA OFFICER, 101-A CHADWICK SQUARE COURT, HENDERSONVILLE, NC 28739.

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature **Date**

_____
For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ **An emergency existed & a signature was not possible at the time.**
- ☐ **The individual refused to sign.**
- ☐ **A copy was mailed with a request for a signature by return mail.**
- ☐ **Unable to communicate with the patient for the following reasons:_____**
- ☐ **Other:_____**
  _____

Prepared By_____

Signature_____

Date_____