

Medical Practice
Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Cape Fear Arthritis Care's health care operations. The Notice of Privacy Practices also describes my rights and Cape Fear Arthritis Care's duties with respect to my protected health information. The Notice of Privacy Practices is available in the patient reception area and on Cape Fear Arthritis Care's website at www.cfac.co

Cape Fear Arthritis Care's reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Cape Fear Arthritis Care's website.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority