



**HEALTH INSURANCE PORTABILITY and  
ACCOUNTABILITY ACT -- (HIPAA)**

**NOTICE OF PRIVACY PRACTICES**

**Acknowledgement of Receipt**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our (828)-253-4262 or toll free at (800)-506-2550.**

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.**

**Printed Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Medical Record No.** \_\_\_\_\_