

Linda J. Hunt, R.N., L.P.C.

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Acknowledgement of Privacy Notice

I understand that as a healthcare provider, you may share my medical information for treatment, billing and healthcare business purposes only unless I give you written permission to do otherwise. I acknowledge that I have read information that describes how my medical information is used and shared. This is the information at the bottom of the “New Patient Information” form I completed and signed. I understand the organization has the right to change the Privacy Notice at any time. I may obtain a current copy of the notice by contacting Linda J. Hunt, R.N., L.P. C. at (336) 768-3900.

My signature below constitutes my acknowledgement that I have been offered a copy of the notice of privacy practices.

Signature of Patient or Legal Representative

Date

Print Full Name

Date of Birth

If signed by a legal representative, relationship to patient:

Please complete the following if unable to secure written acknowledgement of receipt of Notice.

I was unable to secure a written Acknowledgement of Privacy Notice because:

Patient is physically unable to sign acknowledgement because

Signature of provider _____ **Date** _____