WILL RICHARDSON, MD PA - 1120 BAYVIEW DRIVE

Notice of Privacy Practices Patient Acknowledgement

Patient Name: ___________________________________

Date of Birth: ___________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____________________________________

Today's Date: ___________________________________

Relationship to patient (if signed by personal representative of patient):_____________________________________

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