PLEASE READ
James D. Branch, MD

Acknowledgement of Receipt of Privacy Notice

I understand that as a healthcare provider, my physician or the practice's staff may share my medical information for treatment, billing and healthcare business purposes. I acknowledge that I have been given information that describes how my medical information is used and shared. 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 the Town Run Lane office at 336-723-0748.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices:

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Patient's Full Name Date of Birth

If signed by a legal representative, relationship to the patient:

_____

Please complete following box if unable to secure written acknowledgement of receipt of notice.

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

- ☐ Patient is comatose and no legal representative available to sign
- ☐ Patient is physically unable to sign acknowledgement because _____

_____

- ☐ Other reason: _____

_____ _____
Signature of provider/employee Date

***With whom may your treatment be discussed?_____ Phone _____**

***With whom may your billing information be discussed?_____ Phone _____**

***Do you wish for us to leave detailed messages on answering machine? _____YES _____ NO**