

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Drs. Kunkle and Powell, PA Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Unless I revoke this consent in writing with 30 days notice, I give unrestricted access to my health and billing records through verbal and written communication to the persons listed below.**

\_\_\_\_\_  
Name Relationship Date

\_\_\_\_\_  
Name Relationship Date

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
**For Office Use Only**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
- \_\_\_\_\_