KELLY R. KUNKEL, M.D., P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed a copy of the Notice of Privacy Practices of the office of Kelly R. Kunkel, M.D., P.A., which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient Date (month/date/year)

If the patient is a minor or is otherwise incapable of signing, the personal representative of the patient is:

_____ _____
Printed name of personal representative Signature of personal representative