



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Blue Ridge Cancer Care is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices from BRCC.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Personal Representative \_\_\_\_\_  
(if appropriate)

Signature of Personal Representative: \_\_\_\_\_  
(if appropriate)

Date \_\_\_\_\_

Blue Ridge Cancer Care, Use Only

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**Date acknowledgement received: \_\_\_\_\_ - OR - Reason acknowledgement was not obtained:**  
\_\_\_\_\_