

**Asheville Internal Medicine
60 Livingston Street, Suite 200
Asheville, NC 28801**

NOTICE OF PRIVACY PRACTICE

I, _____, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of my communications between the Practice and myself or others.

Signature

Date