Nephrology and Hypertension Associates, LTD.

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PATIENT NAME: ______________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Nephrology and Hypertension Associates, LTD. Notice of Privacy Practices. **

SIGNATURE OF PATIENT: ______________________________________

DATE: ______________________

PLEASE LIST THREE PEOPLE (FAMILY/FRIENDS) WHO MAY CONTACT US REGARDING YOUR PROTECTED HEALTH INFORMATION: PLEASE DO NOT INCLUDE OTHER PHYSICIANS IN THIS INFORMATION.

1. ____

2. ____

3. ____

! By checking I acknowledge that I do not want my health information discussed with anyone who may call this office with the exception of other healthcare providers.

FOR USE BY OFFICE PERSONNEL ONLY: (COMPLETE IF PATIENT ACKNOWLEDGEMENT NOT OBTAINED)

The patient was provided a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient’s signature acknowledging receipt of the Notice.

An acknowledgement was not obtained because ________________________

Signature of office personnel: ____________________ Date: ______________

<u>If you would like a copy of the Privacy Policy for Nephrology and Hypertension Associates, LTD., this can be obtained as you check in for your visit or by calling our office and requesting.</u>**