

Notice of Privacy Practice Acknowledgement

Renal Physicians, Inc.

I have received a copy of your Notice of Privacy Practices containing a description of how your office may use or disclose my personal health information.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Reason(s) for refusal:
