Acknowledgement of Receipt:

Notice of Privacy Practices (HIPAA)

By signing this form, I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Nephrology Physicians, LLC. may use and disclose my protected health information.

Printed Name _____
(Patient/Parent/Conservator/Guardian)

Signature _____ Date _____
(Patient/Parent/Conservator/Guardian)

FOR NEPHROLOGY PHYSICIANS, LLC. USE ONLY

Inability to Obtain Acknowledgement

To be completed **only** if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

_____

_____
Signature of Nephrology Physicians, LLC. Representative

Date _____