CAPITAL NEPHROLOGY NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

Name of Patient:_____ Date:_____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law

Acknowledgement

I certify that I received a copy of Capital Nephrology, P.C.'s ("Practice") *Notice of Privacy Practices* and that I have had an opportunity to review the Notice of Privacy Practices and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

Date:_____ My Signature:_____

My Printed Name:_____

Date:_____ Signature of Witness:_____

I certify that I am the authorized representative of, and that I have received Practice's *Notice of Privacy Practices* on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date:_____ Signature of Representative:_____

Printed Name:_____

Relationship to Individual:_____

Date:_____ Signature of Witness:_____

A copy of this document must be provided to the person to whom the Notice of Privacy Practices was provided and a copy must be filed in the patient's medical record.

FOR USE BY CAPITAL NEPHROLOGY 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 Practice representative:_____

Printed Name of Practice representative:_____

Date:_____