ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

________________________________ ________________________________
Print Name Date of Birth

________________________________ ________________________________
Patient (or Patient Legal Representative*) Signature Date

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ________________________________

Below is a list of individuals that I authorize to receive my medical information from Colorado Kidney Care. This includes emergency contact, spouse, friends and family members.

☐ Check this box if you do not authorize access to your medical information to any family member, friend or emergency contact. This excludes release to medical professionals, physicians and hospitals.

Emergency Contact:

Name	Relationship	Phone
________	________	________
________	________	________
________	________	________
________	________	________

Year: ________/____________ *Year: ________/____________* *Year: ________/____________*
date / initials *date / initials* *date/initials*