HIPAA Privacy Practice Acknowledgment Statement

I acknowledge I have received a copy of Modern Kidney & Transplant Notice of Privacy Practice for Protected Health Information.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient Signature Date

List any family or friends (if any) that we may talk to regarding your healthcare.

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

List any family or friends (if any) that you authorize to pick up healthcare information such as medical records, prescriptions, medical supplies, etc. on your behalf.

Name: _____Relationship: _____Phone:_____

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Print the telephone number(s) you would like to receive calls about your appointments or test results.

_____ May we leave a detailed message at this number? ___ Yes ___ No
(Telephone Number)

_____May we leave a detailed message at this number? ___ Yes ___ No
(Telephone Number)

I understand that this authorization will stay in effect until revoked by me in writing.