

# NORTHWEST NEPHROLOGY CLINIC

## HYPERTENSION AND NEPHROLOGY

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### HIPAA PATIENT ACKNOWLEDGEMENT

#### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement, but, in refusing, we will not be allowed to process your insurance claims*

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Northwest Nephrology Clinic. A copy of this signed, dated acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

\_\_\_\_\_  
Please **print** your name

\_\_\_\_\_  
Please **sign** your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION.  
(This includes spouse, children, grandchildren, sister, brother, and any care takers who can have access to this your records)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell phone Confirmation
- Home phone Confirmation
- Work phone Confirmation
- Email Confirmation
- U.S. Mail/Postcard

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Email message
- U.S. Mail/Postcard
- Any of the above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW HEALTHCARE INFO VIA:

- Phone Message
- Email
- U.S. Mail/Postcard
- Any of the above**