Oklahoma Kidney Care

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Acknowledgement of Review of Notice of Privacy Practices

Patient Name:________________________________ Date of Birth:_________________________

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

If there are any restrictions/limitations you would like to place on the sharing of your private healthcare information please list:

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***The following individuals are permitted to obtain/review/assist me with my:

______appointment information ______medical records ______Billing records

___________________________ (relationship) ___________________________ (relationship)

___________________________ (relationship) ___________________________ (relationship)

In compliance with this Notice of Privacy Practices I authorize the release of any normal and/or abnormal test results in the following manor: (please check all that apply)

___Yes ___No - Permission to leave recorded message on home phone

___Yes ___No - Permission to speak with my spouse

___Yes ___No - Permission to speak with my child/children

___Yes ___No - Permission to speak with my parents

___Yes ___No - Permission to notify me in writing

___Yes ___No - Other______________________________________

____________________________________ ______________________________

Patient Signature Date

____________________________________ ______________________________

Guardian Signature (if different from patient) Date