KIDNEY & HYPERTENSION
CLINIC OF ALASKA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____

Our Commitment to Your Privacy

Our Practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information. We are required by law to maintain the confidentiality of Health Information that identifies you. By signing this form, you acknowledge that Kidney & Hypertension Clinic of Alaska has made an available copy to you of its Notice of Privacy Practices, which explains how your health information will be handled. HIPPA, the Federal Law concerning Medical Privacy, requires this notice.

I have read the Notice of Privacy Practices. Kidney & Hypertension Clinic of Alaska has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

_____ _____

Signature of Patient or Patient Representative **Date**

Provider Use Only
If the patient was not able, or did not want to sign, please document if the patient was given the notice and reason why the patient did not sign below.

Patient was given the notice: _____ Yes _____ No

Reason signature was not obtained:

Staff Signature:

Date:

Provider Use Only
Form will expire on: _____ Staff Initials: _____ Date: _____