Triangle Kidney Associates P.L.L.C
Acknowledgement of Receipt of Notice of Privacy Practices

By signing this fom1, you acknowledge the Triangle Kidney Associates has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled, HIPAA, the federal law concerning medical privacy. requires this notice.

I have received a copy of the Notice of Privacy Practices. Triangle Kidney Associates have given me the opportunity to ask questions about the notice, and all my questions have been answered.

Patient's Name Printed

Patient or Guardian Signature

Date

Provider Use Only

If the Patient was not able to sign due to an emergency, or does not want to sign, please document if the patient was given the notice, and the reason why the patient did not sign below.

Patient was given the notice _____ Yes _____ No

Reason signature was not obtained: _____