

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Wichita Nephrology Group's Notice of Privacy Practices with the effective date of 09/26/2013.

Signature of Patient/Personal Representative

Date

Relationship to Patient

Patient's Name

For Wichita Nephrology Group Use Only

The above named Patient/Personal Representative was provided with a copy of Wichita Nephrology Group's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify): _____

Signature of Workforce Member Completing Form:

Date

Original to be maintained in Patient's medical record