SOUTHWEST GEORGIA NEPHROLOGY CLINIC P.C.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of **Southwest Georgia Nephrology Clinic P.C.** on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of **Southwest Georgia Nephrology Clinic P.C.**

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

Rebecca Distefano
Practice Manager
1200 N Jefferson St., Albany, Ga. 31701
Phone 229-888-3970
Fax 229-889-9386

_____
Signature of Patient

PRINT NAME: _____

DATE: _____

THIS SPACE TO BE USED BY PRACTICE ONLY.

DATE ACKNOWLEDGEMENT DENIED BY PATIENT:

REASON DENIED BY PATIENT:

NAME OF PERSON REVIEWING DENIAL:

DATE: