



NORTH SOUND KIDNEY PHYSICIANS

HIPAA PRIVACY ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

Our practice is committed to protecting the privacy of your health information. Federal and state privacy laws generally permit us to use and disclose protected health information for treatment, payment, and health care operations without a separate authorization when allowed by law. Our Notice of Privacy Practices explains how your information may be used or disclosed, your privacy rights, and our legal duties.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered or provided access to North Sound Kidney Physicians' Notice of Privacy Practices. I understand that I may request a paper copy at any time. I understand that the practice may revise its Notice of Privacy Practices as permitted by law and that the current notice will be available from the practice.

COMMUNICATION PREFERENCES

Please indicate how we may contact you for routine appointment, scheduling, billing, and other non-emergency practice communications. These preferences do not require the practice to use an insecure method when it determines another method is appropriate.

☐ Phone call	☐ Voicemail	☐ Text message	☐ Email
Preferred phone: _____		Preferred email: _____	

PEOPLE WE MAY SPEAK WITH

I authorize North Sound Kidney Physicians to discuss appointment, billing, and/or health information with the person(s) listed below, subject to any limits I write here. I understand that I may change or revoke this permission in writing, except to the extent the practice has already relied on it.

Name	Relationship	Phone	Information / limits

PATIENT RIGHTS

Depending on applicable law, you may have rights to inspect or obtain copies of your records, request corrections, request certain restrictions or confidential communications, receive an accounting of certain disclosures, and file a privacy complaint without retaliation. The Notice of Privacy Practices contains additional details and instructions for exercising these rights.

SIGNATURE

I have read and understand this acknowledgment. My signature confirms receipt or availability of the Notice of Privacy Practices and the communication choices I selected above. This acknowledgment is not a blanket authorization for uses or disclosures that require a separate HIPAA authorization.

Patient / Legal Representative: _____ Date: _____

Signature: _____

If representative, relationship / authority: _____

For office use if acknowledgment is not obtained: ☐ Patient declined to sign ☐ Emergency / unable to sign ☐ Other: _____

Staff name/initials: _____ Date: _____

Practice contact: North Sound Kidney Physicians | Phone: (360) 982-2210 | Fax: (360) 982-2502

Important: This is a general template for practice use and should be reviewed against the practice's actual Notice of Privacy Practices, communication systems, and applicable federal and Washington requirements before implementation.