

BALBOA NEPHROLOGY MEDICAL GROUP, INC.

RECEIPT OF NOTICE OF PRIVACY POLICY AND PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED OR HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW A COPY OF BALBOA NEPHROLOGY MEDICAL GROUP'S:

NOTICE OF PRIVACY POLICY AND PRACTICES

I UNDERSTAND THAT AMENDMENTS TO THIS POLICY MAY OCCUR IN THE FUTURE AND THAT A CURRENT SUMMARY OF THIS OR THE AMENDED NOTICE WILL BE POSTED IN THE MEDICAL OFFICE FOR MY REVIEW. A COPY OF THE AMENDED NOTICE WILL BE MADE AVAILABLE TO ME ON REQUEST.

Print Name

Date

Signature

Telephone

Date of Birth

Physician

Relationship to Patient (if other than patient)