*Lawrence W. Klein, D.O., FACOI*
*Mark D. Oxman, D.O., FACOI*
*Barbara M. Doerr, PhD., D.O., FACOI*
*Jeffrey J. Kaufhold, M.D., FACP*

Nephrology Associates of Dayton INC

*Jennifer L. Jackson, D.O., FACOI*
*Chukwuma E. Eze, M.D.*
*Ashok K. Ammula, M.D.*
*Shachi S. Lovekar, M.D.*
*Shashikant R. Patel, M.D.*

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement*

Nephrology Associates of Dayton, Inc. respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes all potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

**I have been provided with a Notice of Privacy Practices (available in the medical office waiting area), which provides a more complete description of how my protected health information may be used or disclosed.**

**I understand that Nephrology Associates of Dayton reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the medical office**.

Please Print Name _____ Date of Birth _____

Patient (or patient rep) Signature _____ Date _____

**Please list anyone that you wish to release health information or medical records to (i.e.family member, friend, etc.)**

| Name | Relationship | Phone |
|---|---|---|
| Name | Relationship | Phone |
| Name | Relationship | Phone |

If we are unable to reach you, may we leave a message on your **home** phone number? Yes_____ No_____
If we are unable to reach you, may we leave a message on your **cell** phone number? Yes_____ No_____
May send you update or reminder emails? If yes, please provide your email: _____

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

_____ _____
Reason Date

_____ _____
Employee Signature Employee witness (2nd person)