ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Kristy L. Anderson, ND, LLC
Kristy Anderson, ND
Albuquerque, NM
480-229-1348

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Kristy L. Anderson, ND, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

[Kristy Anderson, ND]
[480-229-1348]

I also understand that I am entitled to receive updates upon request if Kristy L. Anderson, ND, LLC amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, (If signed by someone other than patient) Date

THIS SECTION IS TO BE COMPLETED BY KRISTY L. ANDERSON, ND, LLC
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify):

Name and title:_____

Date: _____