KORU
Wellness Aesthetics NYC

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Medical Record #: _____

Date: _____

My signature on this form acknowledges that I have received a copy of Koru Medical's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Koru Medical and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____
Patient's Signature Date

_____ _____
Signature of Patient's Representative Date
(if patient is unable to sign)

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the agency's Notice of Privacy Practices?
   ☐ Yes ☐ No

2. Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form: _____
_____
_____

_____ _____
Signature of Admitting Clinician Date

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