HIPAA Notice of Privacy Practices - Acknowledgement of Receipt

Robert A. Kolarczyk, M.D. - 1801 State Street, Suite C
Santa Barbara, CA 93101-2482

Karen D. Kolarczyk, Privacy Officer: (805) 569-1000

I hereby acknowledge that I received a copy of Dr. Kolarczyk's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____@ _____

Signed: _____ Date _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

Name and Address of Patient: _____

_____

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