

RODNEY BLUESTONE MEDICAL CORPORATION

RHEUMATOLOGY
(ARTHRITIS AND RELATED DISORDERS)
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SUITE 303
BEVERLY HILLS, CALIFORNIA 90210

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

_____ Date

_____ (Print) patient name

_____ signature

I acknowledge I have received a copy of the Notice of Privacy Practices for the office.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- We were unable to communicate with the patient.
- Due to an emergency situation it was not possible to obtain acknowledgement.
- Other (please provide specific reasons)

_____ Employee signature

_____ date

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.