UROLOGY ASSOCIATES OF KINGSTON

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ________________________ acknowledge that I have received a copy of Urology Associates of Kingston's Notice of Privacy Practices. This Notice describes how Urology Associates of Kingston may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

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(Signature of Patient, or Personal Representative) (Date)

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(Relationship to Patient)