

*New Mexico*  
**CLINICAL RESEARCH & OSTEOPOROSIS CENTER, INC.**

E. Michael Lewiecki, MD, FACP - *Osteoporosis Director*  
Lance A. Rudolph, MD - *Research Director*  
Julia R. Chavez, CNP - *Adult Healthcare*

300 Oak St. NE, Albuquerque, NM 87106  
Tel. (505) 855-5525 · Fax (505) 884-4006  
www.nmbonecare.com

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

By signing this document, I acknowledge that I have received a copy of the NMCROC Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

-OR-

\_\_\_\_\_  
Patient Personal  
Representative (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Birth Date \_\_\_\_\_

**NMCROC USE ONLY**

Date acknowledgement received: \_\_\_\_\_

Signature of NMCROC employee: \_\_\_\_\_

-OR-

Reason acknowledgement was not obtained (declined to sign):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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This acknowledgement must be filed in the patient's medical record, behind the demographic sheet.