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1PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Dr. Shiraz Kassam's Privacy Practices

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Dr. Shiraz Kassam, work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Dr. Shiraz Kassam may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Dr. Shiraz Kassam has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Dr. Shiraz Kassam may update this Acknowledgment and "Notice of Privacy Practices". If I ask, they will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

This practice established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist this practice by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of "Notice of Privacy Practices".

_____ _____ _____

Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)