HIPAA

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED OR I HAVE BEEN PROVIDED THAT OPPORTUNITY TO RECEIVE A COPY OF THE “Notice of Privacy Practice” that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Fareesa Khan LLC and their staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concerns Fareesa Khan LLC operations and responsibilities.

I UNDERSTAND THAT I WILL BE REMINDED OF MY APPOINTMENTS THROUGH TEXT, EMAIL OR VOICEMAIL.

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Signature of patient or authorized to consent Date