

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Ata Ahmad, M.D. PA's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Permission for Treatment: I hereby authorize the physician and/or assistants for the care of the patient named on this record to administer any treatment as may be deemed necessary including examinations or treatment that may be ordered to be performed by clinical personnel. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations or treatments to be performed.

I also understand that I am financially responsible for the related charges or remaining charges following my insurance payment(s).

Permission for Release of Medical Information: I understand and agree that any of the above information may be used, if necessary, for purposes of communication for appointment changes, account receivable, emergencies, etc. Information from any medical records may be released, if necessary, for insurance purposes.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____