Pasha
Snoring & Sinus Center

Raza Pasha, M.D. P.A

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my Protected health information. I understand that the information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment for third- party payers.

- Conduct normal healthcare operations, such as quality assessment and physicians certifications.

I have reviewed, read the office's Notice of Privacy Practices, posted in the lobby. I understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient Name Patient's Signature

_____ _____

Relation to Patient Date