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moukdad MEDICAL

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HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

Federal law (HIPAA) requires that we provide each patient with a Notice of Privacy Practices, which explains how your medical information may be used and disclosed, and how you can access that information.

Please review the statement below and sign to acknowledge receipt or review of this notice.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received (or have been offered) a copy of Moukdad Medical's *Notice of Privacy Practices*.

I understand that this notice explains how my health information may be used and shared for purposes of treatment, payment, and healthcare operations.

I also understand that I may request an additional copy at any time and that Moukdad Medical may revise this notice as permitted by law.

Patient Name: _____

Date of Birth: _____

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

FOR OFFICE USE ONLY

☐ **Patient refused to sign acknowledgment**
☐ **Notice mailed to patient on:** _____
☐ **Reason patient did not sign:** _____

Staff Initials: _____ **Date:** _____