SHIFA PSYCHIATRY
Shazia Tayyab, M.D.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights of privacy regarding my protected health information. I understand, however, that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assurance and provider authorization of services.
- Comply with legal obligations to release.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I understand this organization has the right to change its Privacy Practices from time to time and that I may contact the organization at anytime to obtain a current copy of this notice.

I acknowledge and understand that the privacy notices are posted in the lobby and I can access them at www.counselingconnections.net. If I ask for a copy one will be provided to me.

Patient Name (print) ______________________________

Patient Signature (if 12 or older) ______________________________

Parent/Guardian Signature ______________________________

(if patient is 17 or under)

Date ____________________ ____________________

Initial Received Office Policy

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________ Initial: __________ Reason: ______________________________

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I have received a copy of the office and financial policy and medication refill policy.

Signature ______________________________ Date ____________________