PREM SAHASRANAM
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (eg. insurance carrier) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and outcomes

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

_______________________________________ _____________________
SIGNATURE DATE

____
PATIENT'S NAME

_______________________________________ _____________________
WITNESS DATE

Acknowledgement of Receipt of Notice of Privacy Practices was not signed as noted below:

____ Patient refused to sign
____ Patient was physically unable to sign

The following attempts were made to obtain signature:

DATE	TIME	EXPLANATION	INITIALS