Mohammed Ahmad, MD
Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that either:

_____ I have **received a copy** of Mohammed Ahmad's Notice of Privacy Practices;

OR

_____ I **declined** the offered copy of Mohammed Ahmad's Notice of Privacy Practices. I have been informed that a copy of the Notice of Privacy Practices is available to me in the waiting room.

This Notice describes how Mohammed Ahmad, MD may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____	_____	_____
Patient Print Name	Patient Signature	Date
_____	_____	_____
Patient Authorized Representative	Representative Signature	Date

_____
Relationship to Patient