Please note that there will be a $25.00 charge for any missed appointment. All patients are required to know if they need a referral for any testing. Please pick up your referral from your primary care doctor. ***PLEASE SIGN:_____***

DECCA MOHAMMED, MD

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

DESIGNATION OF DISCLOSURE

I. ACKNOWLEDGEMENT OF PRIVACY NOTICE

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FORM

_____	_____	_____	_____
PATIENT NAME	**DATE OF BIRTH**	**SIGNATURE**	**DATE**

II. DESIGNATION OF CERTAIN RELATIVE, FRIENDS, AND OTHER CAREGIVERS

I AGREE THAT DR. MOHAMMED DISCLOSE CERTAIN OF MY HEALTH INFORMATION TO FAMILY MEMBER, CLOSE PERSONAL FRIENDS, OR OTHER CAREGIVERS BECAUSE SUCH PERSON IS INVOLVED WITH MY HEALTH CARE OR PAYMENT RELATING TO MY HEALTH CARE. IN THAT CASE, DR. MOHAMMED WILL DISCLOSE ONLY INFORMATION THAT IS DIRECTLY RELEVANT TO THE PERSON'S INVOLVEMENT WITH MY HEALTH CARE OR PAYMENT RELATING TO MY HEALTH CARE.

I DESIGNATE THE FOLLOWING PERSONS LISTED BELOW AS PERSONS INVOLVED WITH MY HEALTH CARE OR PAYMENT RELATING TO MY CARE FOR THE PURPOSE OF DR. MOHAMMED MAKING THE LIMITED DISCLOSURES DESCRIBED ABOVE. I UNDERSTAND THAT I AM NOT REQUIRED TO LIST ANYONE. I ALSO UNDERSTAND THAT I MAY CHANGE THIS LIST AT ANY TIME I N WRITING.

PRINT NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____

PRINT NAME _____ RELATIONSHIP _____ DATE OF BIRTH _____

_____
_____

III. I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY

HOME TELEPHONE _____

OK TO LEAVE MESSAGE WITH DETAILED INFORMATION _____
OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY _____

WORK TELEPHONE _____

OK TO LEAVE MESSAGE WITH DETAILED INFORMATION _____
OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY _____

WRITTEN COMMUNICATION (REMINDERS ONLY): OK TO MAIL TO MY WORK/ OFFICE OR HOME ADDRESS

_____	_____
PATIENT/ PARENT/ GUARDIAN SIGNATURE	**DATE**

Please note that there will be a $25.00 charge for any missed appointment.