Amisha N. Shroff
10320 Westlake Drive, Suite 109
Bethesda, Maryland 20817
Office: (301) 469-4775 Fax (301) 469-4776

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third-party payer (e.g. my insurance company)

The day-to-day healthcare operations of your practice (e.g. confirming appointments)

I have also been informed of, and given rights to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these request restrictions. However if you do agree, you are bound to comply with restrictions.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____.

Patient's Name *(Please Print)*: _____

Relationship to Patient *(If Minor)*:_____

Signature: _____