Fouzia Muhammedkarim, MD

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing below I acknowledge that I have been provided with a copy of the Notice of Privacy Practices, which describes how my health information may be used and disclosed, and how I can gain access to my health information.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature

Date

Printed Name

Submit