I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _________________________
Relationship to Patient: _________________________
Signature: _________________________
Date: ____________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please continue at the back)
Individuals may complain to Nasir Ramin, M.D. and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. Nasir Ramin’s contact person for matters relating to complaints is:

Shikeba Ramin  
Centreville-Medical Practice’s Privacy Official  
5715 Centre Square Drive  
Centreville, VA 20120 (703) 631-5151

Please provide the name(s) of person(s) if any, to whom you would permit Centreville-Medical Practice (“CMP”) to disclose personal health information necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e. lab results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List below those individuals (family, friends, etc.) you will allow disclosure of your personal health information from CMP as necessary during the course of your health care services:

<table>
<thead>
<tr>
<th>Name and Relation (circle one)</th>
<th>Allowed Disclosures (circle all or list specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse: ______________________</td>
<td>All or Specific: ____________________________</td>
</tr>
<tr>
<td>Family/Friend_________________</td>
<td>All or Specific: ____________________________</td>
</tr>
<tr>
<td>Family/Friend_________________</td>
<td>All or Specific: ____________________________</td>
</tr>
<tr>
<td>Family/Friend_________________</td>
<td>All or Specific: ____________________________</td>
</tr>
<tr>
<td>Family/Friend_________________</td>
<td>All or Specific: ____________________________</td>
</tr>
</tbody>
</table>

Please initial if you will allow interpreter services if necessary for communication with health care providers. ______ (initials)

I _______________________ (patient name) acknowledge and understand that CMP’s policy is to send copies of test results and/or medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. CMP’s policy is to only disclose specific information necessary for coordination of your health care or medical treatment. Please initial below if NO exclusions or list those providers who you do not want specified private health information to be sent.

______ No Exclusions of Health Care Providers

Do NOT send PHI: Provider Name __________________________  All or Specific _________

Do NOT send PHI: Provider Name __________________________  All or Specific _________

I authorize CMP to provide information which may include my private health information using the following modes of communication initialed below as provided by me:

_____ Home phone with answering machine

_____ Work phone

_____ E-mail

_____ Cell phone with voice mail

_____ Fax machine

_____ Other specify __________

I hereby acknowledge that I have read the pages of Centerville-Medical Practice’s Policy Practices, and have received a copy (if requested).

__________________________________________________________________________

Signature__________________________________________________________________________

Date