



Salman Ahmad, M.D., P.A.

2345 50th Street, Ste. 500 Lubbock, TX 79412 (o) 806-701-5797 (f) 806-701-5798



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have been provided with a copy of this office's "Notice of Privacy Practices".

RECEIVED A COPY

DECLINE A COPY BUT NOTICE IS AVAILABLE

PRINT NAME:	INTERPRETER, IF UTILIZED:
-------------	---------------------------

PATIENT'S SIGNATURE:	RELATIONSHIP TO PATIENT:	DATE:
----------------------	--------------------------	-------

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO PERSONAL FRIEND/FAMILY MEMBER

I, (your name) _____, give my permission to SALMAN AHMAD, MD, PA to discuss my medical condition with the following individuals:

NAME: _____ CONTACT #: _____

NAME: _____ CONTACT #: _____

NAME: _____ CONTACT #: _____

Anyone that is not listed, will not be provided any information regarding patient's health or financial status with the office.

This includes, but is not limited to test results, lab results, treatment options, appointment and payment options.

Signature: _____ Date: _____