Zev Ash, M.D.

Patients Name: _____

Date Of Birth: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

Zev Ash, M.D. has provided me its notice of privacy practices. I have had an opportunity to review the Notice before I sighned the document. I further understand that Zev Ash, M.D. may change the terms of the notice from time to time, and that I may contact the office manager to retain a revised version at any time.

Signature: _____ **Date:** _____

Relationship to patient: _____

CONSENT:

I acknowledge that Zev Ash, M.D. will use and disclose my health information for purposes of treatment, payment, and healthcare operations. For purposes of this consent, health information shall mean any and all information relating to healthcare services provided to me by Zev Ash, M.D., including, without limitation, information relating to services provided to me prior to this date. I understand that if I refuse to sign this consent or if I revoke this consent in the future that Zev Ash, M.D. will not provide treatment to me or arrange for treatment on my behalf , and may discharge me as a patient , to the extent permitted by law.

Signature:_____ **Date:**_____

Relationship to patient:_____