PARGOL SAMANI, M.D., INC.
3927 WARING RD, SUITE C, OCEANSIDE, CA 92056
TEL: (619) 703-7220 FAX: (619) 703-7221

Acknowledgements of Receipt of Notice of Privacy Practice

I herby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in a reception area, and that I will be offered a copy of any amended Notice of Privacy Practice at each appointment. In addition, I give permission to have my medication and allergy history obtained from pharmacies electronically by Pargol Samani M.D., Inc.

☐ Patient
☐ Parent or guardian of minor patient
☐ Guardian or conservator of incompetent patient

Print Name: _____ Phone: _____

Signature: _____ Date: _____

If not signed by the patient, please enter:
Name and Address of the Patient: _____

Disclaimer: This document and the information in it do not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPPA regulations.

I wish to be contacted by Pargol Samani M.D., Inc. in the following manner (check all that apply):

☐ Cellphone: _____
☐ Home Telephone: _____
☐ Work telephone: _____

☐ Leave voice message
☐ Leave message with callback number only
☐ Fax to this number
☐ Give health information to the following family member(s): _____

Patient Signature: _____ Date: _____