SITARA KOMMAREDDI, M.D., PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of Dr. Sitara Kommareddi's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PATIENT NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgment of this **Notice of Privacy Practice Acknowledgment**, but was unable to do so as documented below:

Date:____________ Initials:______________ Reason:______________________