

# OUTLINE OF NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. COMPLETE REPORT AT [WWW.NEUROSPINEDOC.COM](http://WWW.NEUROSPINEDOC.COM) UNDER CONTENT.**

The terms of this Notice of Privacy Practices apply to **Fardad Mobin, M.D.**, operating as a health care provider. The members of this medical practice will share your personal health and medical information as necessary to perform treatment, payment, and health care operations as allowed by law. Following is an outline of the content of this notice.

- I. OUR COMMITMENT TO SAFEGUARD YOUR MEDICAL INFORMATION.
  
- II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:
  - A. Uses and Disclosures Without Authorization
  - B. Uses and Disclosures Requiring Authorization
  
- III. What rights you have regarding your medical information.
  - C. The Right to Inspect and Copy.
  - D. The Right to Request Restrictions
  - E. The Right to Amend.
  - F. The Right to an Accounting of Disclosures.
  - G. The Right to Request Confidential Communications.
  - H. The Right to a Paper Copy of This Notice.
  
- IV. COMPLAINTS
  
- V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES
  
- VI. CHANGES
  
- VII. ACKNOWLEDGEMENT

**OR VISIT OUR WEBSITE @ [WWW.CNSDOC.COM](http://WWW.CNSDOC.COM) FOR THE COMPLETE DOCUMENT (NOTICE OF PRIVATE PRACTICES.PDF).**

---

## **Acknowledgement of Receipt**

I hereby acknowledge that I have received a copy Fardad Mobin, M.D. Notice of Privacy Practices.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of patient or patient's representative

Printed name of patient/patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_