

NORTHWEST GENERAL & COLON-RECTAL SURGERY P.A.

**KHAWAJA AZIMUDDIN M.D.
JUNUK KIM M.D.
800 PEAKWOOD, SUITE 4C
HOUSTON, TX 77090**

I acknowledge that I am responsible for following my physician's recommendations and to do what is necessary to control and treat my condition.

I understand that the sole responsibility of my health and well being is in my hands in view of the above and that I cannot reasonably hold my physician responsible if I do not adhere to his recommendations and/or not take medications as I am instructed to do so.

Patient Signature

NORTHWEST GENERAL & COLON-RECTAL SURGERY, P.A.

**KHAWAJA AZIMUDDIN, M.D.
JUNUK KIM, M.D.**

**PATIENTS NAME:
NOMBRE DEL PACIENTE:**

If for any reason my insurance company does not pay the charges at Northwest General & Colon-Rectal Surgery, P.A. I will be liable for all unpaid balances.

Sip or alguna razon mi compania de seguros no paga a Northwest General & Colon-Rectal Surgery, P.A. es de mi conocimiento que soy responsable por dicho balance.

Signature:

Firma: _____

Date:

Fecha: _____

HIPAA NOTICE OF PRIVACY PRACTICES

I am aware of the HIPAA Notice of Privacy practices for Dr. Azimuddin's office and the copies of the notice are available for me to take upon request.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

I give my authorization to release medical/surgical information to the following designated representatives:

Patient initials:

_____ **My Spouse (Name):** _____

_____ **My Children (Names):** _____

_____ **Other (Name):** _____

_____ **May not be given to anyone other than myself**

I hereby authorize medical information to be relayed to me via:

_____ **Home Phone #:** _____

_____ **Cell Phone #:** _____

_____ **Work Phone #:** _____

_____ **E-Mail Address:** _____

_____ **Left on voice mail/answering machine** _____

Patient Signature: _____

Date: _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature