Medical Practice of
Ramesh R Shah, M.D.P.C.
1703 w 30th St, Ste B
Joplin, MO 64804

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I _____, acknowledge a copy of Ramesh R Shah,
(Print Patient's Name)
M.D.P.C.'s Notice of Privacy Practice has been made available to me and has been advised that upon my request a copy will be provided to me.

I allow _____
(Print Family/Friend Name (s))
to have access, by phone or in the office, to my records/lab results/pathology reports until I otherwise specify.

_____ _____
Signature of Patient Date