ASEEMA RAOSHAN, M.D

11914 ASTORIA BLVD # 450

HOUSTON, TEXAS, 77089

HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT,

OFFICE POLICY ACKNOWLEDGEMENT

CONSENT TO IMMTRAC REGISTRATION

ACKNOWLEDGEMENT FORM

I have received the Notice of HIPPA Privacy Practice and I have been provided an opportunity to review it.

I hereby consent to, and request the medical treatment be provided to my children in accordance with the plan of care established by the Physician. I authorize the release of any medical information necessary to process claims, and also authorize the payment of medical benefits to the Physician described herein, consent for registration of Child and Release of Immunization records to Authorized entities.

If no payment is received from the Insurance Company, I agree to pay the balance.

Signature _____