Manely Ghaffari, MD
129 N. 4th Street, Office 1F
Philadelphia, PA 19106

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: __________________________ Date of Birth: _______________

I acknowledge that I have received a copy of the Notice of Privacy Practices of Dr. Manely Ghaffari, effective November 1, 2011.

Signature (patient or authorized representative): _______________________________

Date: ____________________________________

Relationship/authority (if signed by authorized representative): ____________________