

COASTAL MEDICAL GROUP

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NOTICE OF ACKNOWLEDGEMENT

This is to certify and acknowledge that I, _____
date of birth _____ have reviewed and have given a copy of the Notice of
Privacy Practices for Aslam Loya, M.D., P.A.

I am granting consent to Aslam Loya, M.D., P.A. to use and disclose my protected health
information for the purpose of treatment, payment and health care operations. I give my
permission to check my external prescribing history.

Signature: _____

Date: _____