

MEDICAL DOCTORS

ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been shown a copy of the Notice of Privacy Practices for (DR. REZA ALLAMEHZADEH AND DR. ALIREZA GHAHRAMAN, 24881 Alicia Pkwy Suite N, Laguna Hills, CA 92653), as it is currently in effect. I have read and understand the information presented in the Notice. I understand that I am entitled to receive a paper copy of the notice at any time I request one. I also understand that the Office reserves the right to change this notice. If any future changes are made to the notice, on my next visit or admission following the implementation of such changes, I will be provided a copy of the new notice in effect.

Patient Name _____

Patient Signature _____

Date _____

Restrictions on Patient Information:

Special Contact Requirements:

