

COVE PLASTIC SURGERY

ACKNOWLEDGE AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the notice of Privacy Practices for (Dr. Kalantarian) Medical Practice at 11160 Warner Ave. Suite 119, Fountain Valley, CA 92708. 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 copy of the "Privacy Practice" to review. I also understand that Dr. Kalantarian reserves the right to change notice. If any future changes are made to the notice, on my next visit or admission following implantation of such changes, I will be provided a copy of the new notice in effect.

PATIENTS NAME:

PATIENTS SIGNATURE:

Date:

RESTRICTIONS ON PATIENT INFORMATION:

SPECIAL CONTACT REQUIREMENT: