Inna Amirian DMD

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I _____ acknowledge that I have read and understand the notice of privacy practices for Dr. Inna Amirian. The notice describes certain restrictions on the use and disclosure of my health care information, right that I may have regarding my protected healthcare information, and how Inna Amirian and her staff use and disclose my protected healthcare information. By signing this agreement, I also give Dr. Inna Amirian and her staff permission to contact me by telephone, e-mail, or text message and to leave me a message on an answering machine if necessary, to confirm any future appointments.

_____ _____

Signature of Patient or Guardian Date