ANDREW M. MATTHEW M.D.
JESSICA M. HOCHMAN, M.D.
358 Kanan Road
Oak Park, CA 91377
818-707-0046

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM.

I, _____, have received a copy of Dr. Matthew's and Dr. Hochman's Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian Date

_____
Patient Name

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____
Signature of Parent/Guardian Date

_____
Patient Name