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Acknowledgement & Consent

By signing below, I acknowledge that I have been provided a copy of this notice of Privacy Practices and therefore been advised of how health information about me may be used and enclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV / AIDS and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payments for services given to me, and for the business operations of this practice, its physicians, and staff.

Patient Name: _____

Signature: _____ Date: _____

Relationship: _____