Notice of Privacy Practices

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Tamir H. Keshen, M.D. , Charles J.H. Stolar M.D & Sang I. Lee, M.D. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information.
We encourage you read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (805) 563-6560 or Rocio@sbpedsurg.com.

If you have any questions about our *Notice of Privacy Practices*, please contact the number above.

I acknowledge receipt of the *Notice of Privacy Practices* of:Dr.Keshen/Dr.Stolar/Dr. Lee

Signature: _____ Date: _____.
(Patient/parent/guardian)

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it not possible to obtain the individual's acknowledgment was obtained:

Signature of provider representative: _____Date:_____

Efforts made to distribute Notice

_____
_____
_____
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