Patient Consent

I have reviewed the information that explains how your office will use my/my child's personal information and the steps your office is taking to protect my/my child's information.

I know that your office has a Privacy Code and I can ask to see the Code at any time.

I agree that ***Dr. Raj-Deep Mahal*** *can collect, use and disclose personal information about* _____ *as set in the information about the office's Privacy Policies*

_____ _____

Signature **Print Name**

_____ _____

Date **Signature of Witness**