RAVIN JAIN, M0D0

Diplomate, American Board of"Ru{ej kcvt{"cpf"P gwtqrqi{"
Assistant Clinical Professor, UCLA

I have read the enclosed **Notice of Patients Privacy Rights and Release of Medical Information.**

Print name:_____________________________ Date:__________________

Signed:____

Date of Birth: _________ Social Security No.:_______-_____-__________

Please check the appropriate boxes below:

- ❑ You may call my home phone to leave me medical information.
- ❑ You may **NOT** call my home phone to leave me medical information.
- ❑ You may send medical information to my home.
- ❑ You may **NOT** send medical information to my home.
- ❑ You may give medical information to my spouse/other(Name:_________________)
- ❑ You may **NOT** give medical information to my spouse.

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