

Last Name, First Name, MI \_\_\_\_\_ Date Of Birth \_\_\_\_\_

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**Purpose: This form is used to confirm that individual has received our Notice of Privacy**

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I, \_\_\_\_\_, acknowledge that I have received Bruce V. Lattyak, M.D., Inc. Physician Practice's Notice of Privacy Practices. I have had a full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If this authorization is signed by a personal representative on behalf of the individual, complete the following:**

Personal Representative's name: \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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**PHOTOGRAPHY CONSENT**

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It is standard procedure for Dr. Lattyak and/or his staff to take pre- and post-operative photographs of his patients. Some photographs are necessary for submitting to insurance companies in order to receive authorization prior to Dr. Lattyak performing a surgery. Other photographs are taken pre- and post-operatively to simply document the patients results.

Please consent to one of the following:

\_\_\_ I consent to use my photograph for patient care only.

\_\_\_ I consent to use my photograph for patient care, scientific presentations or patient education.

Further consent will be obtained from patients prior to the use of photographs for advertising or marketing purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**NOTICE TO CONSUMERS**

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Medical doctors are licensed and regulated  
by the Medical Board of California  
(800) 633-2322  
[www.mbc.ca.gov](http://www.mbc.ca.gov)