

**ACKNOWLEDGEMENT OF
"NOTICE OF PRIVACY PRACTICES"**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly;
- obtain payment from third-party payers;
- conduct normal health care operations such as quality assessments and physician certifications.

I have had the opportunity to receive, read and understand your "Notice of Privacy Practices", containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that any changes will be posted in the doctor's office, and that I may contact this organization at any time to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PRINT NAME _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this "Notice of Privacy Practices", but was unable to do so as documented below.

Initials _____ Date _____

Reason _____



Member

AMERICAN SOCIETY OF
PLASTIC SURGEONS