ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPAA NOTICE

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of California Institute of Plastic and Reconstructive Surgery, d.b.a. Changes Plastic Surgery's Notice of Privacy Policies.

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Please print your name here

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Signature

____

Date

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

____ Patient refused to sign

____ Due to an emergency situation it was not possible to obtain an acknowledgment

____ Unable to communicate with the patient

____ Other (Please provide specific details)

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Employee Signature *Date*