SOMERSET PLASTIC SURGERY

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Check Physician Box

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices give you information about how we use and disclose medical information about you (HIPAA).

By signing this form, you are acknowledging that you received a copy of our Notice of Privacy Practices.

Name of Patient: _____

_____ _____

Patient or Personal Representative Signature **Date**

_____

Representative's Relationship to Patient

……

For internal office use only:

If not signed, reason:

☐ Patient refused to sign ☐ Other _____

☐ Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments:

_____

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_____ _____

Name of Reviewer Date