Hackney Plastic Surgery Center
Acknowledgement of Receipt of
Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Hackney Plastic Surgery Center reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

____ _______________________

Patient's Printed Name Date of Birth

____ _______________________

Patient/Legal Representative Signature Date

____

Relationship to Patient

____ _______________________

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Hackney Plastic Surgery Center to share my protected health information with:

____ _______________________

Name Relationship

____ _______________________

Name Relationship

____ _______________________

Name Relationship