Member
AMERICAN SOCIETY OF PLASTIC SURGEONS, INC

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I (print your full name)…………………………...Hereby Acknowledge receipt of the physician's **NOTICE OF PRIVACY PRACTICES FORM.** The NOTICE OF PRIVACY PRACTICES provides detailed information about how the practice may use and/or disclose my confidential information.

I understand that the physician has reserved the right to change his/her privacy practices as described in the aforementioned NOTICE. I also understand that a copy of my revised NOTICE will be provided or made available to me.

Signed:…………………………..Date…………………

If you are not the patient, please specify your relationship to the patient.

………………………………...

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