ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This is an acknowledgement of receipt only.

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

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1. Can we call you at home? Yes or No

2. Can we leave a message for you at home? Yes or No

3. Can we leave a message for you at work? Yes or No

4. With whom may we discuss your medical condition:

    1. _____

    2. _____