TEXAS PLASTIC SURGERY ASSOCIATES

ACKNOWLEDGMENT OF RECIEPT OF PRIVACY PRACTICE NOTICE

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

Reason for refusal:

_____