## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name ____________________________________Date of Birth__________________
Social Security Number ___________________________________________

1. I acknowledge that New Leaf Plastic and Reconstructive Surgery, has provided me with a written copy of their Notice of Privacy Practices. __________ (Initial)

2. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. __________ (Initial)

3. I acknowledge that New Leaf Plastic and Reconstructive Surgery will disclose my Protected Health Information to a family member, other relative, close friend or any other person I identify that directly relates to that person's involvement in my care. __________ (Initial)

Person(s)______________________________ ________________________
(Relationship) (Relationship)

**OR**

__________ (Initial) I object to the disclosure of my Protected Health Information to a family member, other relative, close friend or any other person.

4. I acknowledge that New Leaf Plastic and Reconstructive Surgery may communicate with me via US mail, home phone number, or cell phone number. __________ (Initial)

5. I request for an alternative method of communication such as alternative address or work phone number. __________ (Initial)

Alternative method:__________________________________________________

___________________________________________ ________________________
Patient Signature Date

___________________________________________ ____________
Personal Representative Signature (if applicable) Relationship to Patient


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