RENUE PLASTIC SURGERY

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Renue Plastic Surgery's Notice of Privacy
Patient/Guardian Name

Practices.

_____
Please Print Name

_____ _____
Signature Date

MY ACKNOWLEDGEMENT REGARDING USE AND RELEASE OF INFORMATION TO PERSONS INVOLVED IN MY CARE

The following family members, friends or others will be involved in my/the patient's health care, and I agree that Renue Plastic Surgery can discuss my/the patient's health information, and other information pertinent to my/the patient's care and treatment at Renue Plastic Surgery, such as billing and payment obligations, with the following individuals, relevant to their involvement in my/the patient's health care.

I/the patient understand **I do not have to list anyone**, but if I do, then Renue Plastic Surgery can communicate with those individuals as permitted by the Health Insurance Portability and Accountability Act (HIPAA).

Print Full Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign.
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (Please specify.)

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