facial Beauty

NOTICE OF PRIVATE PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Patient's Name:_____

In compliance with HIPPAA, we will not disclose your to records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see the record or get more information by contacting our office. We keep a record of the health care services we provide you. You may ask to see and/or obtain a copy of that particular record. You may also ask to correct the record.

Our notice of private practices describes in more detail how your health information may be used and disclosed and how you can access your information. Please review the post of notice of private practices in our office before your appointment.

- ☐ Please do not disclose my information with anyone unless the law authorizes or compels you to do so.
- ☐ The person or persons marked below may have excess to my information (i.e. spouse, friends, or family members).

Name _____ Relationship_____

Name _____ Relationship_____

I acknowledge that I have received a notice of private practices.

_____ _____

Patient signature Date

OR

_____ _____

Parent or legally authorized individual's signature. Date