NOTICE OF RECEIPT OF THE HIGHLY ARTISTIC SURGERY PRIVACY PRACTICES

I have received, read and understand Highly Artistic Surgery's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the Highly Artistic Surgery at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you must restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: