Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____

Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____
_____
_____
_____

For Internal Use Only

If patient refuses to sign acknowledgement, please document the date and time notice was presented to patient and sign below.

Presented on (date and time) _____

By (Name and title) _____

hCG & Aesthetic Medicine Clinic, LLC