

# The AESTHETIC SURGERY CENTRE'

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Dear Patient,

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received this Notice.

You have the right to review our notice before signing this acknowledgement, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

I authorize the following person to obtain medical information on my behalf:

None [  ]

Name \_\_\_\_\_ Relationship \_\_\_\_\_

We appreciate you signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

Patient Name: \_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Main Tacoma Office:	2202 South Cedar, Suite 300 Tacoma, WA 98405	253.627.2900
Federal Way Office:	34503 9 <sup>th</sup> Avenue South, Suite 230 Federal Way, WA 98003	253.838.3657