

**Health Insurance Portability and Accountability Act (HIPAA)**

**NOTICE OF PRIVACY PRACTICES / OFFICE POLICY**

**ACKNOWLEDGEMENT OF RECEIPT(s)**

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I was provided with a copy of the Northern Center for Plastic Surgery Notice of Privacy Practices and Office Policy.

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Patient Name (Print) Patient Signature

**If completed by a patient’s personal representative, please print and**

**sign your name in the space below**

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Personal Representative (Print) Personal Representative’s Signature

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Relationship