

Acknowledgement of Receipt of Notice of Privacy Practices

Laser & Cosmetic Surgery Specialists, PC reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices for Laser & Cosmetic Surgery Specialists, PC.

Name of Patient (print or type)

Signature of patient

Date

Signature of patient representative (required if the patient is a minor
Or an adult who is unable to sign this form).

Relationship of patient representative

There may be occasions when you want to give another person the ability to discuss your treatment with Laser & Cosmetic Surgery Specialists, PC (appointments, billing, treatment, etc.). This authorization will allow discussion only. This does not authorize release of medical records.

I give permission for Laser & Cosmetic Surgery Specialists, PC to share information verbally regarding my treatment at Laser & Cosmetic Surgery Specialists, PC with the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____