Rosenthal Cosmetic Surgery & Skin Care Center

140 Sherman Street

Fairfield CT 06824

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

*Obtain payment from third party payers.

*Conduct normal healthcare operations such as quality assessments and physician Certifications

I have been given the opportunity to acquire a summary of your Notice of Privacy Practices and understand that I have access to the Notice containing a more complete description of the uses and disclosure of my health information. I understand that this office has the right to change its ***Notice Of Privacy*** Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

Patient Name:____

Relationship(if patient is a minor):____

Permission to Speak with Family Members: Y ____N ____ If yes, whom: ______________________________________

Date: ______________

Signature: ____

OFFICE USE ONLY

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

Date: __________

Initials: __________