

Notice of privacy practice acknowledgement

**Umansky Medical Center for Plastic Surgery
4150 Regents Park Row #260
La Jolla, CA 92037**

I understand that, under the Health Insurance Portability & Accountability act of 1996(HIPPA), 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 multiple healthcare providers who may be involved in that treatment directly and indirectly

Obtain payment from third party payers

Conduct normal healthcare operations such as quality assessment and physician certificates

I acknowledge and I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures if my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree you are bound to abide by such restrictions.

Print name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

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

DATE

INITIALS

REASON