West Maple Plastic Surgery

NOTICE RECEIPT ACKNOWLEDGMENT

Purpose: This form is used to confirm that an individual had received West Maple Plastic Surgery's Practice Notice of Privacy Practice.

I, _____, acknowledge that I have received West Maple Plastic Surgery's Practice Notice of Privacy Practice. I have had a full opportunity to read and consider the content of this Notice of Privacy Practice.

Signature:_____ Date: _____

Permission for disclosure of information:

I, _____, give permission for Dr. Sherbert, or any member of his office staff, to discuss my case, insurance or surgical information with the following:

_____, relationship to patient _____

_____, relationship to patient _____

Signature:_____ Date: _____

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