



Kaufman & Clark Plastic Surgery

ACKNOWLEDGEMENT OF PATIENT PRIVACY NOTICE

I have been informed of **Kaufman & Clark Plastic Surgery** Patient Privacy Practices. I am aware that this notice describes how medical information about patients may be used and disclosed and how I can get access to this information. I have been requested to review it carefully. I am aware that I have the right to a paper copy of this notice and may ask for a copy at any time. I may obtain a paper copy of this notice by asking the staff or writing to **Kaufman & Clark Plastic Surgery**.

I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Name _____
Please print *Date*

Signature of patient: _____

I authorize **Kaufman & Clark Plastic Surgery** to discuss medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify **Kaufman & Clark Plastic Surgery**, in writing, whenever this information changes.

Spouse Name: _____

Parent Name: _____

Other Name: _____
give name and relationship (ie boyfriend, sister, friend, etc.)

Signature of Patient: _____
Date