Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I received or read a copy of Dr. Jeffrey Herrold and Arkansas Institute for Cosmetic and Plastic Surgery's Notice of Privacy Practices. The Privacy Notice details how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Privacy Notice.

I request the following restriction(s) & reason(s) concerning the use of personal medical information.

_____

_____

_____

Authorization of Release of Medical or Financial Information

Please list below any person(s) in addition to your referring physician and their practice or your insurance company that you are authorizing to receive or discuss medical records or financial information regarding your visits with our practice. I understand that if my personal identity is changed or compromised in any way, it is my responsibility to contact and inform Dr. Jeffrey Herrold and Arkansas Institute for Cosmetic and Plastic Surgery.

Name	Relationship to Patient and phone number
1)	
2)	
3)	
4)	

Further, I permit a copy of this acknowledgement with or without restrictions to be placed in my medical record. I also understand that I can cancel or amend my NPP at any time by writing a letter to the administrator making the necessary changes.

Signed: _____Date: _____

If not signed by the patient, please indicate relationship

- Patient or guardian of minor patients
- Guardian or conservator of any incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient _____

Relationship to Patient _____Date: _____