



THE NEW YORK
AESTHETIC CONSULTANTS
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PLASTIC SURGERY
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Accredited by The Joint Commission

**NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have been informed that the U.S. Government requires
Patient Name

I sign this Notice of Privacy Practices. The privacy regulations were created by the U.S.
Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patient privacy.

I understand that the full text of the Act is available to me upon request. In order to request any
amendments, restrictions or disclosures I must make a written request to the office HIPAA Privacy
Officer.

Signature of Patient

Date