ACKNOWLEDGEMENT OF PATIENT PRIVACY NOTICE

I have been informed of the ***Clark Plastic Surgery, Inc.*** *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* ***Clark Plastic Surgery, Inc.***

I hereby grant permission (if deemed necessary) 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 ***Clark Plastic Surgery, Inc.*** *to discuss medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify* ***Clark Plastic Surgery, Inc.****, 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

2220 East Bidwell St. Folsom, CA 95630
916-983-9895 fax 916-983-9850
www.clarkplasticsurgery.com