

***Receipt of Notice of Privacy Practices***

***Acknowledgment of Receipt of Notice of Privacy Practices***

***The Center for Aesthetic & Reconstructive Surgery***

***My signature on this form indicates that I have been made aware of a Notice of Privacy Practices for The Center for Aesthetic & Reconstructive Surgery. If you have any questions, please contact the Privacy Officer whose name and contact information is listed below.***

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***Name of patient or Personal Representative (printed)***

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***Signature of patient or Personal Representative***

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***Date***

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***Personal Representative's Relationship or Authority***

***Privacy Officer  
Mary Wallmuth / Susan Gochoco  
The Center for Aesthetic & Reconstructive Surgery  
25 Monument Rd Ste 292  
York, Pa. 17403***