ULTIMA
MEDICAL & AESTHETICS

A Premier Medical Practice!

ACKNOWLEGEMENT RECEIPT OF PRIVACY PRACTICES NOTICE

I have received or I have been provided the opportunity to receive a copy of "Notice of Privacy Practices" that tells me how and why my confidential health information may be disclosed or shared. I acknowledge that Ultima Medical & Aesthetics staff and physician may disclose and share my health information with other providers or agencies in order to treat me, arrange payment for services rendered and concerning healthcare operations and responsibilities.

Date: _____

Signature of Patient and/or Legal Guardian: _____

Name of Patient and/or Legal Guardian: _____

Signature & Name of Staff member providing this notice: _____

If personal representative signs this authorization on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Should a patient and/or legal guardian not receive a copy of the "Notice of Privacy Practices", please document below the good faith effort to obtain the individual's written acknowledgment or receipt of Privacy Practices, that it was not obtained and the reason why the individual would not sign this form:

_____

_____

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