

**NOTICE OF PRIVACY PRACTICES**  
**GARCIA PLASTIC SURGERY**

THE NOTICE DESCRIBES HOW MEDICAL PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Summary:**

By law, we are required to provide you access to our Notice of Privacy Practices (NPP). The notice describes how your medical information may be used and disclosed by us. It tells you how you can obtain access to this information.

As a patient of Garcia Plastic Surgery, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request your information be restricted.
4. The right to request confidential communication.
5. The right to a report of disclosures of your information
6. The right to a copy of the Notice of Privacy Practice.

We want to assure you, your medical protected health information is secure with us. We will insure you information remains private.

If you have any questions regarding the Notice of Privacy Practices, please contact our office manager.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/HIPPA:**

I hereby acknowledge that I have reviewed a copy of Garcia Plastic Surgery's Notice of Privacy Practices. I understand that if I have any concerns regarding my rights, I may contact your office manager for assistance. I further understand Garcia Plastic Surgery will provide me with updates to the Notice of Privacy Practices as they become available.

**I agree** to allow Garcia Plastic Surgery to leave detailed messages on my answering machine, regarding my appointments? **Yes** or **NO** (*please circle one*)

**I agree** to allow Garcia Plastic Surgery to provide medical information to the following person(s):

\_\_\_\_\_

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Witness

*For office use only:*

Patient Refused to sign

Patient unable to sign