NOTICE OF HEALTH INFORMATION PRACTICES
ACKNOWLEDGEMENT FORM

AUSTIN PLASTIC SURGERY INSTITUTE

The attached notice describes how medical information about you may be used and disclosed and how you can receive access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I received the Notice of Health Information Practices of **Dr. William Gorman MD, FACS**, I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used and disclosed and that the organization is not required to agree to the restriction request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____
Name of Patient

_____
Signature of Patient

_____
Date