NORTHEAST PLASTIC SURGERY
CENTER

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Nilay Shah, MD
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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the practice of Northeast Plastic Surgery Center, LLC. I understand that if I have further questions or complaints, I may contact:

Administrative Coordinator
Northeast Plastic Surgery Center, LLC
5 Davis Road East
Old Lyme, CT 06371
860-390-6000 (O)
860-215-8150 (F)
info@northeastpsc.com

I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy Practices is amended or changed in a material way.

_____ _____

Signature Date

If not signed by the patient, please indicated below your relationship to the patient.

Patient Representative:

If you are the legally authorized representative of the patient, please **check the appropriate box** indicating your authority to act on the patient's behalf		Parent
		Durable Power of Attorney for Health Care (attach proof of authority)
		Legally Authorized Representative (attach proof of authority)
		Personal Representative of the Estate (attach proof of authority)
		Other (specify and attach proof of authority)

Individuals involved in your care or payment for your care: Unless you object, we may disclose health information about you to a family member, close personal friend, or other person you identify who is involved in your care or arranging payment for your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.