



Acknowledgment of Receipt of Privacy Policy (HIPAA Policy)

I have received the Notice of Privacy Practices for Vega Aesthetic and Reconstructive Surgery (VARS).

Patient Name (Printed)

Signature of Patient (or Representative) **Representative may be a parent, legal guardian, health care surrogate*

Date of Signature

Printed Representative Name

Relationship of Representative to Patient

If signature was not obtained, please indicate why:

Patient Refused **Emergency Situation** **Other Reason:** _____

Name of Witness (VARS Staff Member) (Printed): _____

Witness Signature: _____

Date: _____

Note: This document is to be retained for six years in accordance with the HIPAA Privacy Rules.