John M. Rowley, M.D.
Palo Verde Plastic Surgery

Acknowledgement of Receipt of Privacy Notice

(Original to be maintained in patient's permanent medical record)

I hereby give my consent to John M Rowley, MD and/or "this practice" to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent related to the Privacy Notice:
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing.

Please allow those listed below access to my Protected Health Information (PHI):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

By signing below, I acknowledge that I have reviewed and understood the Notice of Privacy Practices. I know I have a right to obtain a copy for my records

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name of Patient or Responsible Party Date