DR. SUZANNE YEE
Cosmetic & Laser Surgery Center

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I received or read a copy of Dr. Suzanne Yee, Cosmetic & Laser Surgery Center's Notice of Privacy Practices. The Privacy Notice details how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Privacy Notice.

Red Flag Rule

I also understand a "Red Flag Rule" policy has been put in place to protect my information against identity theft. I hereby acknowledge that I received or read a copy of the "Red Flag Rule" and understand the contents.

I request the following restriction(s) & reason(s) concerning the use of personal medical information.

_____

_____

_____

Authorization of Release of Medical or Financial Information

Please list below any person(s) in addition to your referring physician and their practice or your insurance company that you are authorizing to receive or discuss medical records or financial information regarding your visits with our practice. Your patient ID # will consist of the last 4 digits of your drivers license number. Any persons listed below MUST PROVIDE THIS NUMBER. I understand that if my personal identity is changed or compromised in any way, it is my responsibility to contact and inform Dr. Suzanne Yee's Cosmetic & Laser Surgery Center.

Name	Relationship to Patient

Further, I permit a copy of this acknowledgement with or without restrictions to be placed in my medical record.

___-___-___-___ (please enter last 4 digits of DLN)

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____ Date: _____

For Office Use Only:

- Signed form received by: _____ Date: _____