SAN ANTONIO PLASTIC SURGERY INSTITUTE
Michael E. Decherd, md pa

Acknowledgement of Review of Notice of Privacy Practices
(HIPPA)

I have reviewed this office's **Notice of Private Practices**, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

I authorize the office of Dr. Decherd to release information of my behalf to the person(s) listed below:

1. _____

2. _____

3. _____