HIPAA FORM

ANGELA KEEN,M.D.
Plastic Surgery & Skin Care

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FOR ANGELA KEEN M.D.

I acknowledge that I have had the opportunity to read the HIPAA Notice of Privacy Practices policy of the office of Angela Keen MD. I understand that I may request a paper copy of the Notice of Privacy Practices for my own records, make changes to my health information or ask questions at any time.

Any matter of financial dispute will not be coverable by HIPAA.

Patient's Name:

Patient's Signature: **Date:**

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