



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**MEDISPA MAUI
BRIAN STOLLEY M.D., INC.
1445 South Kihei Road, Kihei HI 96753**

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name (Print): _____

Signature: _____

Self-Other (explain): _____

Circle one

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:

Initials:

Reason:
