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Acknowledgment of Notice of Privacy Practices

I have received a copy of the notice of privacy practices for Dr. Robert Morin and East Coast Aesthetic Surgery, P.C.

I understand that Dr. Robert Morin and East Coast Aesthetic Surgery, P.C. reserves the right to modify the privacy practices outlined in the notice.

Name of Patient

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient