Acknowledgement of Receipt of Notice of Privacy Practices

Center for Hand & Extremity Reconstructive Surgery, PLC

Joseph M. Failla, MD

Patient Name: _____

Date of Birth: _____

I acknowledge receiving a copy of the Center for Hand & Extremity Reconstructive Surgery, PLC, Notice of Privacy Practices.

Signature or initials of patient or authorized representative: _____

Printed Name of patient or authorized representative: _____

Date: _____

***authorized representatives include:**

- **Legal Guardian**
- **Emancipated Minor**