

**Anti Aging Arts Medical Center  
Robert F. Sterner Jr MD  
1516 W, Redwood St. Ste. 202  
San Diego CA, 92101  
619-543-1061/619-543-0043 fax**

**Notice Of Privacy Practices**

This acknowledgement is to be filled out by patients whose medical services have been rendered at the offices of Robert F. Sterner, Jr. M.D., Anti-Aging Medical Center. The patient receives the original Notice of Privacy Practices. Only the Acknowledgement of Receipt is filed in the patient's medical record.

**Acknowledgment of Receipt**

My signature below acknowledges I have been given a copy of Robert F. Sterner, Jr. M.D. and the Anti-Aging Medical Center's Notice of Privacy Practices.

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Personal/Legal Representative of Patient. If required by law, please state relationship.

\_\_\_\_\_  
Signature of Personal/Legal Representative of Patient

\_\_\_\_\_  
Date