

**CENTER FOR PLASTIC & RECONSTRUCTIVE SURGERY**

**CALVIN R. PETERS, M.D.**

**KENDALL K. PETERS, M.D.**

2501 NORTH ORANGE AVE., SUITE #442; ORLANDO, FL 32804

PHONE: 407-898-1436 FAX: 407-898-6330

**ACKNOWLEDGEMENT OF  
RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

My signature on this form indicates that I have **received** a Notice of Privacy Practices.

Please contact the Privacy Officer whose name and contact information is listed below if you have any questions.

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**Name of Patient**

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**Signature of Patient or Legal Guardian**

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**Name of Legal Guardian (if applicable)**

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**Date**

**Privacy Officer:**

**Kathy Wingerter**

**Privacy Officer**

**Center for Plastic & Reconstructive Surgery**

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**Orlando, FL 32804**

**(407) 898-1436**