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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy
(Patient Name)

of A to Z Dermatology NOTICE OF PRIVACY PRACTICES. This notice describes how A to Z Dermatology may use and disclose my protected health information, restrictions on the use of disclosure of my health care information, and rights I may have regarding my protected health information.

(Signature of Patient or Personal Representative)

(Date)

(Relationship to Patient)

Personal Representative (family members, attorney, etc.): I hereby authorize A to Z Dermatology and its employees to discuss send and or receive medical information to the following.

Please provide their names and phone numbers below:

1. Name _____ Relationship _____
Phone# _____

2. Name _____ Relationship _____
Phone# _____

3. Name _____ Relationship _____
Phone# _____