Acknowledgement of Receipt of Notice of Privacy Practices

Coastline Dermatology Laser and Medical Center

400 Newport Center Dr. #501 Newport Beach CA 92660

(949)646-2311

I acknowledge that a copy of the current Notice of Privacy Practices will be available to me upon request.

I hereby authorize release of information related to my personal health, treatment, lab/pathology

results to my primary care physician; _____

Ph# ( )_____

I hereby authorize release of information related to my personal health, treatment, lab/pathology

results to my insurance carrier.

( ) Do ( ) Do Not Leave messages on my voicemail.

If you are unavailable;

( )Do ( ) Do Not Leave messages with _____

at ph# ( )_____

Signed:_____ Print Name: _____

Date:_____

If not signed by the patient, please indicate relationship:

_____