Acknowledgement of Receipt of Notice of Privacy Practices

Genesis Dermatology reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE
I have received a copy of the Notice of Privacy Practices for Genesis Dermatology.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient
Receipt of Notice of Privacy Practices

OFFICE USE ONLY

Attempt to Obtain Acknowledgement
An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

[ ] The patient was undergoing emergency treatment
[ ] The patient declined to sign the acknowledgement
[ ] Other_____

_____
Signature of patient (or patient representative) Date

Name of Staff Member