Douglaston Dermatology

Receipt of Notice of Privacy Practices

Notice to patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge that you have received our Notice of Privacy Practices.

☐ Received Physical Copy ☐ Waived Physical Copy

____

Patient's name Patient's Date of Birth

____

Personal Representative name Relationship to Patient

____

Signature Date

For Office Use Only

In the case that written acknowledgement could not be obtained, please select reason below.

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify):____________________________________

____ __________________

Signature of Workforce Member Completing Form Date