DERMATOLOGY HEALTH SPECIALISTS

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Receipt of Notice of Privacy Policy Practices

I hereby acknowledge that I have been informed of and given the right to review and secure a copy of the Notice of Privacy Practices for Dermatology Health Specialists. These privacy practices set forth the ways in which my personal health information may be used or disclosed by Dermatology Health Specialists, and outlines my rights with respect to such information.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I have read, understand, and agree to the privacy policies.

_____ _____

Patient Signature Date

Print Patient Name _____

Relationship to Patient (if applicable) _____

Signature (if applicable) _____