Center for Advanced Dermatology

Acknowledgement of Notice of Privacy Practices

May we leave personal medical information on your voice mail? ☐ Yes ☐ No

Do you give our office permission to discuss your medical information with family members? ☐ Yes ☐ No

If yes, please provide their names and phone numbers below.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

I hereby acknowledge that I received and understand the Center for Advanced Dermatology's Notice of Privacy Practices.

_____ _____

Patient Name *(Please Print)* Date of Birth

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Legal Guardian's Printed Name *(If applicable)*

Relationship to Patient: ☐ Parent ☐ Legal Guardian

(For office use only)
Documentation of Good Faith Efforts

The patient presented to the office on _____ Center for Advanced Dermatology's Notice of Privacy Practices (Notice). A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ The Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ❑ Other reason (please describe): _____

_____ _____

Signature of Employee Completing Form Date