

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

MARTIN DERMATOLOGY

I, _____ have read a copy of MARTIN DERMATOLOGY'S
Patient name

Notice of Patient Privacy Practices.

Signature of Patient or
Parent or legal Guardian

Date

If you would like this office to be able to discuss your information with another person or family member, please authorize below.

Name(s) of person(s) we can discuss your information with

_____	Relationship	_____
_____	Relationship	_____
_____	Relationship	_____

The above authorization can be revoked at any time in writing.