**Notice of Privacy Practices**

**Acknowledgement of Receipt**

I acknowledge that I was provided with a copy of the Empire Dermatology notice of privacy practices.

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Patient Name (Print) Patient Name (Signature) Date

**I give Empire Dermatology permission to discuss my medical results with:**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If completed by a patient’s personal representative, please print and sign your name below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative Name (Print) Representative Name (Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship

**For Empire Dermatology staff only**. Complete this section if this form is not signed and dated by the patient or patient’s representative.

I have made in good faith effort to obtain a written acknowledgement of receipt of Empire Dermatology Notice of Privacy Practices, but was unable to for the following reasons.

󠄀Patient refused to sign

󠄀Patient unable to sign

󠄀Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name Date