SUTTON
DERMATOLOGY + AESTHETICS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Patient Name: _____
(Last) (First) (Middle)

Medical Record #_____

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Relationship to Patient Witness/Date

I AUTHORIZE THE DISCLOSER OF MY MEDIACAL INFORMATIN TO THE FOLLOWING INDIVIDUALS (FAMILY MEMBERS OR FRIENDS ONLY, NO DOCTORS PLEASE). IF NO ONE, PLEASE WRITE "NONE" THEN SIGN AND DATE.

_____ _____ _____

_____ _____
Signature of Patient/Parent/Legal Guardian Date

GOOD FAITH EFFORT

_____ Presented the Notice of Privacy Practices to the Patient/Parent/Legal Guardian, but they declined to acknowledge receipt.

_____ Patient/Parent/Legal Guardian stated they have already received the Privacy Notice.

_____ Patient/Parent/Legal Guardian directed to SDA's waiting room for a copy of the Notice of Privacy Practices.