ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Medical Record #____________
office use only

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

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

________________________________ ____________________
Name Relationship to patient

________________________________ ____________________
Name Relationship to patient

________________________________ ____________________
Signature of Patient/Parent/Legal Guardian Relationship and Date

________________________________ ____________________
Witness Signature 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 a copy of the Notice of Privacy practices.**

_____ **Patient/Parent/Legal Guardian directed to Sutton Dermatology & Aesthetics waiting room for a copy of the Notice of Privacy Practices.**