

Saginaw Bay Dermatology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient

Interpreter (if applicable)

Pursuant to the Notice of Privacy Practices I hereby authorize release of my medical information to the below named individuals. I know I may rescind this authorization at any time by providing a new, signed copy of the Privacy Practices Acknowledgement.

Authorized Person #1

Relationship

Authorized Person #2

Relationship

Witnessed by: