Cinco Ranch
DERMATOLOGY

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Cinco Ranch Dermatology Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Patient Name: _____

Patient/Responsible Party Signature: _____

Date: _____

If you are not the patient, please fill out the following information:

Responsible Party Name: _____

Responsible Party DOB: _____

Relationship to Patient: _____

Address: _____

Telephone: _____

People allowed access to my medical records:

Name / DOB: _____

Name / DOB: _____

Name / DOB: _____