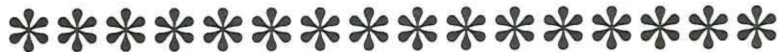
WHITE ROCK DERMATOLOGY

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

Our Notice of Privacy Practices provides information as to how we may use and disclose protected health information about you. You have been given a copy of our Notice of Privacy practices. The terms of our Notice may change. You may obtain a revised copy by contacting our office.



By signing this form, I acknowledge that I have received a copy of the Notice Of Privacy Practices and consent to the disclosure of protected health information about me for treatment, payment and health care operations as described in the Notice of Privacy Practices. White Rock Dermatology provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

______________________________________ ____________________

Signature of Patient or Patient Representative **Date**

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Relationship to Patient
(if signed by other than patient)