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NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

This "Notice of Privacy Practices Form" helps to ensure the privacy of your medical records. I acknowledge that I have had the opportunity to read and review a copy of Southeastern Dermatology, P.A.'s "Notice of Privacy Practices." A copy of this notice is available in our waiting room. I understand that this notice protects my privacy and the privacy of Southeastern Dermatology, P.A.

I authorize Southeastern Dermatology, P.A., to contact me by phone, mail, e-mail, phone messages, or text messages regarding my medical-surgical care, special offers, or upcoming events.

Name

Signature

Date

If there is someone who should receive your Personal Protected Health Information other than yourself, please list this information below:

_____ _____

Their Name **Relationship**

_____ _____

Their Name **Relationship**

This ACKNOWLEDGEMENT form will be retained in your medical record. If you do not wish to sign this acknowledgement, please give your reason below.
