Acknowledgement of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Nigro Dermatology Group's Notice of Privacy Practices.

____
Patient's Name

_________________________ __________
Signature of Patient Date

I give my permission to share my medical information with:

__ Spouse/Other ________________________

__ Voicemail

__ Email _____________________________________

For Office Use Only

Patient was given a copy of the NIGRO DERMATOLOGY GROUP'S Notice of Privacy Practices but refuses to sign the acknowledgement.

____
Print Employee's Name

______________________________ __________
Signature of Employee Date