GEORGETOWN
DERMATOLOGISTS, P.C.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of birth: _____/_____/_____

Signature: _____ Date: _____/_____/_____

----------*Office Use Only*----------

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Signature: _____ Date: _____/_____/_____

Reason: _____

CONSENT TO SHARE PERSONAL HEALTH INFORMATION

I give my permission for the following people to have unlimited access to my medical records, appointment information, and billing information at Georgetown Dermatologists, PC. I understand that the following people will be able to make and cancel appointments for me, and discuss billing questions and medical information with the staff at Georgetown Dermatologists, PC.

I also understand that at any time, I can remove any of the names from the list in writing, and they will no longer have access to my information.

NAME	RELATIONSHIP	PHONE NUMBER

Patient Signature: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____