ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Integrated Dermatology

481 Gold Star Highway, Suite 201
Groton, CT 06320
(860)445-8020

Patient Name____

I hereby acknowledge that I have been offered a summary or full copy (my Preference) of the Integrated Dermatology Notice of Privacy Practices. I understand that I may request a copy of any amended Notice of Privacy Practices at any time.

Signed____________________________________Date______________

Printed name______________________________Phone______________

If not signed by the patient, please indicate your relationship to the patient: ______________

____

____

For office use only:

Signed form received from________________________________

Refused to sign:

Reason for refusal:______________________________________

Efforts to obtain: ______________________________________