SURGICAL DERMATOLOGY ASSOCIATES DALLAS, P.A.

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Patient Acknowledgement of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed and/or received a copy of this office's Notice of Privacy Practices explaining:

- How the office will use and disclose my protected health information.
- My privacy rights with regards to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information.

I understand the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy upon request.

I also understand that if I have any questions or complaints, I may contact the Office Manager.

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient Name: _____ Date of Birth ____/_____/_____

SIGNATURES:

Patient or Legal Representative: _____ Date ____/____/_____

If Legal Representative, relationship to Patient: _____

For Office Use Only

We make a good faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ◉ **Patient refused to sign (date of refusal ____/____/_____).**
- ○ **Communication barriers prohibited obtaining an acknowledgement.**
- ○ **An emergency situation prevented SDA Dallas from obtaining an acknowledgement.**
- ○ **Other**_____

Attempt was made by :_____**Date**____**/**____**/**_____