NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Phoebe Rich Dermatology Notice of Privacy Practices.

By signing below, I attest that I have both received a copy and agree to our Notice of Privacy Practices.

_______________________________________ Patient Signature	_______________ Date
_______________________________________ Print Patient Name	

-OR-

_______________________________________ Parent, Guardian, Responsible Party, Legal Representative Signature	_______________ Date
_______________________________________ Description of Representative's Authority	

© Oregon Medical Association