

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received a copy of the
Phoebe Rich Dermatology & Oregon Dermatology and Research
Center 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	