

Dermatologic Surgery of Central Virginia, PLC

Form 023: Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that I have been provided with a copy of **Dermatologic Surgery of Central Virginia, PLC's** Notice of Privacy Practices dated February 15, 2011 pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____ Signature of Patient (or Representative)	_____ Date
_____ Printed name of Patient	_____ Printed name of Representative
	_____ Relationship to Patient

Evidence of the authority of the patient's representative must be attached to last page of this acknowledgment

If patient is unable to sign please document the reason and initial: _____

- I hereby give **Dermatologic Surgery of Central Virginia, PLC** permission to leave messages on my telephone answering machine or to whom ever answers the telephone.
- I hereby give **Dermatologic Surgery of Central Virginia, PLC** permission to give information about my health and/or medical condition to the person(s) listed below:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____

_____ Signature of Patient (or Representative)	_____ Date
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In order for you, or anyone else, to obtain information from our office about your health and/or medical condition by telephone, the party calling must share a unique and specific patient identifier with our staff.

Patient Identifier: _____