



*advanced*  
DERMATOLOGY

**ACKNOWLEDGMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

Thank you for choosing Advanced Dermatology for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided a copy of our Notice.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient (or Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date