MR#:_____ Patient Name:_____ DOB:_____

DermOne™
Dermatology, Cosmetic
& Scarless Vein Center

ACKNOWLEDGMENT OF CONSENT OF NOTICE

NOTICE TO PATIENT:_____

We are required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICE**, which states how we may use and/or disclose your health information. Please sign this form to acknowledge your consent of our NOTICE on the previous page. You may refuse to sign this acknowledgment, if you wish.

I acknowledge my consent to this office's **NOTICE OF PRIVACY PRACTICES**.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our **NOTICE OF PRIVACY** from this patient, but it could not be obtained because:

1. The patient refused to sign.
2. Due to an emergency situation, it was not possible to obtain an acknowledgement.
3. We weren't able to communicate with the patient.
4. Other (please provide specific details):_____
   _____