

Franklin Dermatology Group

Notice of Privacy Practices Acknowledgement

Patient Name: _____ DOB: ____/____/____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

A copy of the Franklin Dermatology Group *Notice of Privacy Practices* was made available to me. It contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Franklin Dermatology Group at any time to obtain a current copy of the *Notice of Privacy Practices*.

Signature of Patient or Personal representative

Date

FRANKLIN DERMATOLOGY GROUP USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:
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