Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Atlanta Dermatologic Surgery Consultants, P.C.

I hereby acknowledge receipt of Atlanta Dermatologic Surgery Consultants, P.C.'s Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Atlanta Dermatologic Surgery Consultants, P.C.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

OFFICE USE ONLY

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

Date:	Initials:	Reason: