TREASURE COAST DERMATOLOGY

# Acknowledgement of **Notice of Privacy Practices**

My signature below verifies that I ________________________________ have received
Print Name
a copy of Treasure Coast Dermatology's Notice of Privacy Practices.

____________________________________ ________________________
Signature of Recipient Date

## **P**rotected **H**ealth **I**nformation Authorization

**Optional:**

My signature below authorizes Treasure Coast Dermatology to discuss my PHI with my spouse or personal representative:_____________________________________________
Print Name of Spouse or Personal Representative

I understand that I may revoke my consent in writing at any time.

____________________________________ ________________________
Signature of Patient Date