THE CENTER FOR Skin Cancer SURGERY

PRIVACY NOTICE ACKNOWLEDGEMENT

PURPOSE: This form is used to document (a) an individual's acknowledgment of receipt of our Privacy Practice Notice or (b) when we have not obtained this acknowledgment, our good faith effort to obtain the acknowledgment. This notice is available in print at our office or on our website.

Patient Name: _____ Date of Birth: _____
Notice Version (date): February 27, 2017

Acknowledgment of receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Privacy Practices Notice from The Center for Skin Cancer Surgery, Inc. at 8057 Spyglass Hill Road, Suite 102, Melbourne, FL 32940.

Individuals who may receive my medical information:
Name/Phone: _____
Name/Phone: _____
Name/Phone: _____
Name/Phone: _____

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgment of receipt):
Describe your good faith effort to obtain the individual's signature on this form: _____
_____

Describe the reason why the individual would not sign this form: _____
_____

(TO BE COMPLETED BY OFFICE STAFF)
I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____