Acknowledgement of Receipt of Notice of Privacy Practice for Greenbrae Dermatology

Lucretia Lewitt, Privacy Officer (415) 925-0550

I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" and that I will be offered a copy of any amended Notice of Privacy Practices.

Please initial that you have read and understood each item. If you wish to make changes to a section, please notify the front desk so you file is noted properly in our computer. Please sign and date the bottom of the page.

_____I acknowledge that I have received a copy of the office's Privacy Practices.

_____I give permission for the staff to identify themselves as a doctor's office when calling my home or office. I understand that no test results or other identifiable medical information will be left, just the time and date of the appointment. I give permission to leave a message to contact our office. The following exceptions apply :
_____ I authorize the following person(s)_____ (for example a spouse, family member or friend) to have access to my medical information, such as being able to receive my test results, take advice regarding my condition, and make my appointments. I may change this at any time by signing a new form. Their phone number_____

_____Greenbrae Dermatology physicians, upon request, or as he/she sees appropriate, will keep my primary care or referring physician notified of my condition/progress.

_____I authorize the staff to release pertinent records to any physician that Greenbrae Dermatology refers me to for further care.

_____I understand that my records will not be released to third-party marketers without my explicit agreement.

_____I understand that business associates such as billing processors may have access to some aspects of my medical information, but these entities have shown that they adhere to strict privacy practices. Any breach of this privacy will be reported.

_____I understand I may request copies of my medical records and they can be copied at a charge and delivered within 30 days. Electronic records may be sent electronically.

Print Patient
Name_____Date:_____

Signed_____ Relationship to Patient_____