SOUTHEASTERN Dermatology

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Southeastern Dermatology. I hereby acknowledge receipt of Southeastern Dermatology'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 Southeastern Dermatology's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____