ALLURE DERMATOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received
(Name of Patient)

a copy of ALLURE DERMATOLOGY **'Notice of Privacy Practices'.** This Notice describes how ALLURE DERMATOLOGY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)