

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)