GARDEN CITY DERMATOLOGY
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Phone: 516-227-3377 Fax: 516-227-3378

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have had an opportunity to read and receive a
Patient Name

copy of Garden City Dermatology's Notice of Privacy Practices.

I authorize Garden City Dermatology to leave information regarding my medical treatment on my voicemail or answering machine unless otherwise informed. I authorize Garden City Dermatology to discuss my Protected Health Information (PHI) (i.e. laboratory results, biopsy results) with the following family members:

Name	Relationship

_____________________________________ _____________________
Signature of Patient/Guardian Date