Dermatology Associates

OF MONTGOMERY, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DERMATOLOGY ASSOCIATES OF MONTGOMERY, LLC

Dermatology Associates of Montgomery may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (TPO). Please refer to **Dermatology Associates of Montgomery's** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. **Dermatology Associates of Montgomery** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Dermatology Associates of Montgomery's** Privacy Officer, Carolyn Barrett, at 286 Mitylene Park Drive, PO Box 241627, Montgomery, AL 36124-1627.

Dermatology Associates of Montgomery may call my home or other designated location and leave a message on voicemail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. **Dermatology Associates of Montgomery** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and laboratory results among others. **Dermatology Associates of Montgomery** my FAX to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and laboratory results among others. I have the right to request that **Dermatology Associates of Montgomery** restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I acknowledge **Dermatology Associates of Montgomery's** use and disclosure of my PHI to carry out TPO. If I do not sign this acknowledgement, **Dermatology Associates of Montgomery** may decline to provide treatment to me.

_________________________________	_____________________________________
PRINT NAME OF PATIENT	SIGNATURE OF PATIENT OR LEGAL GUARDIAN
_________________________________	_____________________________________
DATE	PRINT NAME OF LEGAL GUARDIAN