

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Thank you for choosing *Dermatology Treatment & Research Center, P.A.* for your healthcare needs.

We are required by Texas law to provide you with a copy of our *Notice of Privacy Practices*. To ensure that our records are accurate, please sign this form and return it to our front office to acknowledge that you have been provided with a copy of our Notice.

Signature of Patient (or Legal Representative)

Date

Signature of Staff Member

Title

Date

I authorize the person(s) below to have access to all my records, including lab and pathology reports.

Name

Relation to patient

Name

Relation to patient