McKay
DERMATOLOGY & MEDSPA

Your Privacy Is Important to Us

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy Practices of McKay Dermatology and MedSpa. I hereby authorize, as indicated by my signature below, McKay Dermatology and MedSpa to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____
Print Name(Circle one: Patient/Parent/Legal Guardian) Address

_____ _____
Signature Date

Please check your preferred means of communication:
Pt. Initials

_____ You may contact me/leave message at my home telephone number:_____

_____ You may contact me/leave message on my mobile telephone number: _____

_____ You may contact me/leave message on my work telephone number:_____

_____ You may send me an unencrypted email at: _____

_____ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____
   Name/Relationship
2. _____Date Added / Removed: _____
   Name/Relationship
3. _____Date Added / Removed: _____
   Name/Relationship

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____