

Georgia Dermatology, LLC

ACKNOWLEDGEMENT OF PATIENT PRIVACY PRACTICES

I understand that Georgia Dermatology, LLC has a responsibility to protect patient privacy. To do that, the practice strives to keep patient information confidential and to safeguard the privacy of patient information.

I understand that Georgia Dermatology, LLC has the authority to use and disclose private health information to carry out treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have been provided with the right to review Georgia Dermatology, LLC's Notice of Privacy Practices and have been informed that I may obtain a copy upon request.

I further understand that Georgia Dermatology, LLC reserves the right to change their Notice of Privacy Practices. Should Georgia Dermatology, LLC change its notice, I may obtain a revised copy by contacting the office.

Print Name

Signature

Date