RECEIPT of NOTICE of PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

DERMATOLOGY ASSOCIATES OF SOUTH JERSEY, LLC

I am a patient of Dermatology Associates of South Jersey. I hereby acknowledge receipt of Dermatology Associates of South Jersey's Notice of Privacy Practices.

NAME: _____

(please print)

SIGNATURE: _____

DATE: _____

OR

I am a parent or legal guardian of _____. I hereby acknowledge receipt of Dermatology Associates of South Jersey's Notice of Privacy Practices with respect to the patient.

NAME:_____

(please print)

Relationship to Patient: _____ Parent _____ Legal Guardian

SIGNATURE:_____

DATE:_____