

Receipt of Notice of Privacy Practices
Written Acknowledgement Form
King Dermatology

I am a patient of King Dermatology. I hereby acknowledge receipt of King Dermatology's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: ____/____/____

OR

I am a parent or legal Guardian of _____ (patient name). I hereby acknowledge receipt of King Dermatology's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to patient: ____ Parent ____ Legal Guardian

Signature: _____

Date: ____/____/____