

200.007 Patient Acknowledgement of Receipt of Notice of Privacy Practices

SKIN AND CANCER CENTER OF ARIZONA
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____ Date of Birth: _____

I acknowledge that I have been provided the Skin and Cancer Center of Arizona's ("Practice") Notice of Privacy Practices ("Notice"):

- It tells me how Practice will use my health information for the purposes of my treatment, payment for my treatment, and Practices health care operations.
- The Notice explains in more detail how Practice may use and share my health information for other than treatment, payment, and health care operations.
- Practice will also use and share my health information as required/permitted by law.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Address

Description of Personal Representative's Authority

Telephone