MOORESTOWN DERMATOLOGY ASSOCIATES, PA

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____,
HAVE BEEN NOTIFIED THAT UPON MY REQUEST I WILL RECEIVE A COPY OF MOORESTOWN DERMATOLOGY ASSOCIATES NOTICE OF PRIVACY PRACTICES.

PLEASE INDICATE THE PHONE NUMBERS WHERE MESSAGES CAN BE LEFT.

HOME# _____

WORK# _____

CELL# _____

PLEASE IDENTIFY THOSE PEOPLE YOU WISH TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION:

SPOUSE:(NAME) _____(PHONE#)_____

PARENT:(NAME)_____(PHONE#)_____

CHILD:(NAME)_____(PHONE#)_____

FRIEND:(NAME)_____(PHONE#)_____

RELATIVE:(NAME)_____(PHONE#)_____

GUARDIAN:(NAME)_____(PHONE#)_____

POWER OF ATTORNEY:(NAME)_____(PHONE#)_____

SIGNATURE:_____ DATE: _____