Central Oregon Dermatology
Mark Hall, MD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been given the opportunity to receive a copy of our **Notice of Privacy Practices** ("Notice"). This Notice explains how we plan to use and disclose your protected health information ("Health Information") for the purposes of treatment, payment and health care operations in accordance with the **Health Insurance Portability and Accountability Act** of 1996 ("**HIPAA**"). The Notice applies to the privacy practices of Central Oregon Dermatology, P.C.

You have the right to review our Notice of Privacy Practices prior to signing this form. It provides detail on how we may use and disclose your Health Information. The Notice may change. A current copy may be requested by contacting our Privacy Officer at (541) 678-0020 or visiting our website at: http://centraloregondermatology.com.

By signing below, I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices.

Signature of Patient or Patient Representative:

X_____ _____ _____ _____

Signature **Print Name** **Date of Birth** **Date**

_____

Relationship to Patient/Legal Authority

For more information, contact our Privacy officer at (541) 678-0020

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgment
____Other (please specify):_____
_____

_____ _____

Staff Signature **Date**