

**REED & FISHER DERMATOLOGY
ACKNOWLEDGEMENT OF RECEIPT**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Reed & Fisher Dermatology.

Patient Name (Please Print)

Signature of Patient (or patient's representative)

Date