Lexington–Waltham Dermatology Group, P.C.

57 Bedford Street, Suite 201

Lexington, MA 02420

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________________________, have reviewed a copy of Lexington-Waltham Dermatology Group, P.C.'s Notice of Privacy Practices.

_______________________________________ ______________________

Signature of Patient/Guardian Date

____

Name of Patient (if different from signature)

I give permission to release my medical records and information to the following person(s):

____

Name

____ ________________________

Patient Signature Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

_______________________________________ _______________________

Employee's Name Date

____

Reason