South Charlotte Dermatology

Acknowledgment of Receipt
Of Notice of Privacy Practices

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) & understood the notice.

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Patient Name (Print)

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Patient/Authorized Representative / Parent (if applicable)

Authorization for Release of Information

I hereby authorize South Charlotte Dermatology to disclose my individual medical information to the person(s) listed below. I understand that this authorization is voluntary and will not expire, however it may be revoked at any time by notifying South Charlotte Dermatology in writing.

Person(s) allowed to receive my Medical Records	Relationship to Patient

___________________________________ ______________________

Signature **Date**