

MANATEE DERMATOLOGY

Terrence T. Hopkins, M.D.
Bruce W. Fuller, M.D., Ph.D.
Board Certified Dermatologists
Christa Hall, P.A.-C

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____(Signature) _____(Date)

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (please specify) _____

RELEASE OF INFORMATION TO OTHERS

We at Manatee Dermatology take your privacy seriously. We understand at times you may want us to disclose your Protected Health Information (PHI) to members of your family or other trusted individuals who are a part of your care. Please list below the name(s) and phone number(s) of those who may request medical information about you and to whom we may release your PHI.

1. Name: _____ Phone: _____

Relationship: _____

2. Name: _____ Phone: _____

Relationship: _____

We will honor this request until you rescind or edit your permission to release your PHI.

Patient Signature: _____ Date: _____