

# **OB** ORMOND BEACH DERMATOLOGY

## WRITTEN ACKNOWLEDGEMENT FORM

**I am a patient** of Ormond Beach Dermatology. I hereby acknowledge receipt of Ormond Beach Dermatology's Notice of Privacy Practices.

Name [please print]: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**OR**

**I am a parent or legal guardian** of \_\_\_\_\_ [patient name]. I hereby acknowledge receipt of **Ormond Beach Dermatology's Notice of Privacy Practices** with respect to the patient.

Name [please print]: \_\_\_\_\_

Relationship to Patient:

Parent

Legal Guardian

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_ Patient declines copy of Notice of Privacy Policy.

305 Clyde Morris Blvd., Suite 150 • Ormond Beach, FL 32174  
Phone 386-615-1771 • Fax 386-615-1545