Receipt of Notice of Privacy Practices

Patient's Name____ **Chart #** _______________

This notice given to you describes how medical information about you may be disclosed. Please review it carefully.

I acknowledge receipt of this notice

______________________________ Signature of Patient or Legal Guardian	______________________________ Relationship to Patient
______________________________ Print Patient's Name or Legal Guardian	______________________________ Patient's Date of Birth
______________________________ Witness	______________________________ Date

In conjunction with these privacy practices you will need to provide us with the following information:

Name of person(s) we may speak to regarding your health or that you would like to have contact us on your behalf (i.e., spouse, child, etc. including phone number(s). This includes picking things up for you. Please put <u>none</u> if there is no one you would like to have access. This information stays in place until it is changed by you. If you would like to have someone added or removed later please call our office.

** Please place a check in the box next to the person you would like us to contact in an emergency.

	Name	Relationship	Phone Numbers
☐	______________________	______________________	______________________
☐	______________________	______________________	______________________
☐	______________________	______________________	______________________
☐	______________________	______________________	______________________
☐	______________________	______________________	______________________

1330 Oak Lane Suite 101, Lynchburg, VA 24503
(434) 847-6132
Website: www.lynchburgdermatology.com