GARDEN CITY DERMATOLOGY
901 Stewart Avenue, Suite 201, Garden City, New York 11530
Phone: 516-227-3377 Fax: 516-227-3378

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have had an opportunity to read and receive a
Patient Name
copy of Garden City Dermatology's Notice of Privacy Practices. I authorize Garden City Dermatology to leave messages on my voicemail.

I authorize Garden City Dermatology to discuss my Protected Health Information (PHI) (i.e. laboratory results, biopsy results) with the following family members:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Patient/Guardian Date