

Delaware Valley Dermatology Group, LLC

HIPAA ACKNOWLEDGEMENT

I acknowledge that I have received the **Notice of Privacy Practices** for Delaware Valley Dermatology Group, LLC.

Name of Patient (Please Print)

Date of Birth

X

Signature of Patient (or Guarantor)

Date

Name of Guarantor, if applicable (Please Print)

Relationship to Patient

******IMPORTANT!! If you wish that anyone, including family members, be able to access your medical and/or insurance and billing information with DVDG, please list the person(s) in the section below and sign.******

ASSIGNMENT OF PERSONAL REPRESENTATIVE

I request that Delaware Valley Dermatology Group, LLC share any and all of my private health information with the following person(s) listed below. If I choose to revoke this privilege, I understand that I must do so in writing.

Name of Personal Representative (Please Print)

Relationship to Patient

Name of Personal Representative (Please Print)

Relationship to Patient

Name of Personal Representative (Please Print)

Relationship to Patient

X

Signature of Patient (or Guarantor)

Date