

# South Charlotte Dermatology

## Acknowledgment of Receipt Of Notice of Privacy Practices

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) & understood the notice.

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient/Authorized Representative / Parent (if applicable)**

## Authorization for Release of Information

I hereby authorize South Charlotte Dermatology to disclose my individual medical information to the person(s) listed below. I understand that this authorization is voluntary and will not expire, however it may be revoked at any time by notifying South Charlotte Dermatology in writing.

<b>Person(s) allowed to receive my Medical Records</b>	<b>Relationship to Patient</b>

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**