OHIO SKIN CENTER

DERMATOLOGY • SURGERY • COSMETICS

ACKNOWLEDGEMENT OF RECEIPT OF OHIO SKIN CENTER PRIVACY NOTICE

I have received a copy of Ohio Skin Center's Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

I request the following restriction(s) concerning the use of my personal protected health information:

Signature: **Date:**

Patient Name: **Witness:** _

If not signed by patient, please indicate relationship to patient: _

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _

By (name and title): _

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