ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dermatology Clinic of Jackson, P.C.'s Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling telephone number (731) 422-7999 or by requesting one at the following office:

Dermatology Clinic of Jackson, P.C.
ATTN: Privacy Officer
1320 Union University Drive
Jackson, TN 38305

Date **Signature**

_____ _____

_____
(Print or Type Name)

As the representative of _____, I acknowledge receipt of the Notice on his or her behalf.

Date **Signature**

_____ _____

_____
(Print or Type Name)

_____
Relationship