



KENTUCKY DERMATOLOGY CLINIC

120 State Avenue, Glasgow, KY 42141

Phone: (270) 651-0344

Fax: (270) 651-0446

www.kydermclinic.com

Patient name: _____ Date: _____

Account number: _____

**Acknowledgement of Receipt
of Notice of Privacy Practices**

Consent for Release of Information

I acknowledge that I have received a copy of the Kentucky Dermatology Clinic’s Notice of Privacy Practices. *I give the Kentucky Dermatology Clinic permission to use and disclose Protected Health Information for treatment, payment, and health care operations, as described in the Notice of Privacy Practices.*

Patient or patient’s representative

If signed by a person other than the patient, please state the relationship to the patient.

Relationship: _____

To be completed by Kentucky Dermatology Clinic staff, in case no signature was obtained:

I certify that I have provided the above named patient a copy of the Clinic’s Notice of Privacy Practices, and that I have made a good faith effort to obtain the patient’s written acknowledgement of its receipt.

The written acknowledgment of receipt has not been obtained due to:

- The patient’s physical condition
- The patient’s refusal to sign the tendered acknowledgement
- Other, explain: _____

KDC staff member