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10973 S.E. 175th Place Suite 100
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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of the Skin Cancer Center of Central Florida Notice of Privacy Practices. I understand that I can request a paper copy of this document.

By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____
Patient Name (Type or Print) Date

_____
Signature

FOR OFFICE USE ONLY

Patient refuses to sign acknowledgement of Notice of Privacy Practices.

_____ _____
Staff Signature Date