Updegraff Clinic for Allergy and Dermatology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIVES

Patient Name ______________________________ Patient DOB ______________________

By signing below, I acknowledge that I have received **the Notice of Privacy Practices of Updegraff Clinic for Allergy & Dermatology, P.C.**, an Arizona professional corporation, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

______________________________________ ______________________________

Signature of Patient/Patient's Representative Date

______________________________________ ______________________________

Printed Name of Patient/Patient's Representative Representative's Authority to Sign

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OFFICE USE ONLY

I,____________________________________, have made a good faith effort to obtain written acknowledgement of 's receipt of the Notice of Privacy Practices of Updegraff Clinic for Allergy & Dermatology, P.C.; however, I could not obtain written acknowledgement due to:

(please check the appropriate box)

☐ Individual refused to sign the Acknowledgement

☐ communication barrier prohibited obtaining written acknowledgement

☐ An emergency situation prevented obtaining written acknowledgement

☐ Other (please specify

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