



RECEIPT of HIPAA Notice of Privacy Practices Acknowledgement

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Skin Science Soul by Dr. Sholar is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our office, our medical staff and affiliated healthcare providers that jointly perform payment activities and business operation with our office. "Protected health information" is information about you,

Signature: _____

Date: _____

Patient name: _____

Patient/Health Care Agent/Guardian/Relative Signature

(This signature indicates having received a copy of the Notice of Privacy Practices.)

- Patient is unable to sign due to medical**
 - reasons Patient refuses to sign**
 - Other (Please Explain)**
- _____
- _____

This Acknowledgement Form will become part of your permanent medical record.
