1055 N. La Canada Drive, Ste. 101
Green Valley, AZ 85614
520-589-2039
www. oasisdermaz. com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ____ acknowledge that I have received
(Name of Patient)

a copy of OASIS DERMATOLOGY's **'Notice of Privacy Practices'**. This Notice describes how OASIS DERMATOLOGY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____
(Signature of Patient, or Personal Representative) (Date)

____
(Relationship to Patient)

Personal Representative (Family members, attorney, etc.): I hereby authorize Oasis Dermatology and it's employees to discuss, send and/or receive medical information to/with the following.

Please provide their names and and phone numbers below:

1. Name ____________________________Relationship ___________________
Phone # ________________________________

2. Name ____________________________Relationship ___________________
Phone # ________________________________

3. Name ____________________________Relationship ___________________
Phone # ________________________________