

**ACKNOWLEDGMENT OF REVIEW
OF NOTICE OF PRIVACY PRACTICES**

I have been given the opportunity to review the "Notice of Privacy Practices" of Medical and Surgical Dermatology Center of Northeast Texas, P.A., which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so desire.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority