Pioneer Valley Dermatology, PC

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Acknowledgement of Notice of Privacy Practices

By signing this I acknowledge that I have an opportunity to review the **Notice of Privacy Practices** for Pioneer Valley Dermatology. I understand I may have my own personal copy of this notice if I ask for it, and that the current notice is available for review on Pioneer Valley Dermatology's web site, www.pioneervalleyderm.com.

Patient Name (print) ____

Patient Signature ____   Date: ________

Consent to Speak to or Release Information

Due to HIPAA regulations we are unable to release medical information to anyone other than the patient. IF you would like us to be able to speak with anyone else regarding your medical care (biopsy reports, lab work, appointments, etc.), please indicate their name and relationship to you below.

This release will expire on (***please write in one year from date below or write an alternative date).*** Expiration date : ____.

____   ___________________

Name   Date

____   ___________________

Relationship to patient   Your initials

____   ___________________

Name   Date

____   ___________________

Relationship to patient   Your initials