Skin Care Physicians
OF FAIRFIELD COUNTY
Adult & Pediatric Dermatology

GAIL B. WHITMAN, M.D.

Diplomate of The
American Board of Dermatology

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received/been offered a copy of SkinCare Physicians of Fairfield County Notice of Privacy Practices.

_____ _____

Patient's Signature Date Signed

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To Be Completed by Covered Entity if Unable to Obtain Written Acknowledgement From Patient

On_____, I attempted to obtain a written acknowledgement of *Receipt of Notice of Privacy Practices* from the above patient, but was unable to because:

[ ] Patient declines to sign this written acknowledgement

[ ] Patient did not understand the request to sign the written acknowledgement

[ ] Other (specify):_____

_____ _____

Employees Name & Title Date

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Consent to Disclose Protected Health Information to Family, Friends or Other Representative

By signing below, I hereby authorize, SkinCare Physicians of Fairfield County to disclose my Protected Health information to the following:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Patient's Name (please print) Date Signed

_____

Patient's Signature

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13 Park Street ◆ Norwalk, CT 06851 ◆ 203-847-2400 ◆ Fax 203-847-1126
2890 Main Street, Suite C ◆ Stratford, CT 06614 ◆ 203-375-8200 ◆ Fax 203-375-9424