DR. DONNA A. SERURE, DERMATOLOGY & COSMETIC LASER SURGERY, P.C.
327 Middle Country Road • Smithtown, NY • 11787-2905

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

We are required to provide you with our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Our Notice of Privacy Practices is posted in our waiting room for your review.

Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I, _____, acknowledge that I have had the opportunity to
Patient Name
review a copy of **Dr. Donna A. Serure, Dermatology & Cosmetic Laser Surgery, P.C.'s** Notice of Privacy Practices and have been given the opportunity to request a personal copy.

_____ _____
Signature of Patient Date

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The Patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We were not able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____
Signature of Employee *Date*