4615 Parliament Dr. Suite 204 Alexandria, LA 71303
134 E 5th St. Natchitoches, LA 71457
Phone: 318.321.5245 Fax: 318.542.4322

Notice of Privacy Practices Acknowledgment

Acknowledgement of Receipt

I, _______________________________, hereby acknowledge that Dean Derm has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient/Guarantor Signature:_____________________________Date:__________________________

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

*If not signed, please provide a reason why the acknowledgement was not obtained.

Witness:____Date:_____________________________

(Staff Signature)

Consent to release information

In the event I cannot be reached, I, _________________________, give permission for a representative from Dean Derm, to speak with family member(s) or companion(s) listed below regarding care or test results.

Name:____________________________________Phone:___________________________________

Relationship:____

Name:____________________________________Phone:___________________________________

Relationship:____

Is it OK to leave results or information on your voicemail? YES NO

Patient/Guardian Signature:____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Consent to correspond electronically

While at Dean Derm takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a Dean Derm physician regarding my medical care, that his/her representative has my permission to correspond via that email address.

I give permission for a Dean Derm physician or clinic staff member to email me at

_______________________________________@_________________________ regarding my medical care.

Patient/Guarantor Signature:____________________________________Date:___________________