FRYER DERMATOLOGY, PLLC
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RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES WRITTEN ACKNOWLEDGE FORM

I have had an opportunity to read and receive a copy of the HIPPA notice of Privacy Practices for FRYER DERMATOLOGY, PLLC.

____________________________ ____________________________
Patient name-please print Date

____________________________ ____________________________
Signature of Patient/guardian Relationship to patient

I authorize FRYER DERMATOLOGY, PLLC to discuss my Protected Health Information (PHI) with the following family members or designated individuals.

Name:	Relationship:

____________________________ ____________________________
Signature of Patient/Guardian Date