



THE MENKES CLINIC
Medical, Surgical and Cosmetic Dermatology

NOTICE OF PRIVACY PRACTICES

PLEASE READ ENTIRE FORM AND SIGN AT THE BOTTOM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name: _____ Date: ____/____/____

Signature: _____ Tele: (____) _____

If not signed by the patient, please indicate:

- Relationship: Parent or Guardian of Minor Patient
 Guardian or Conservator of an Incompetent Patient
 Beneficiary or Personal Representative of Deceased Patient

Name of Patient: _____