



**RECEIPT OF NOTICE**  
**PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

I hereby acknowledge that I received the Notice of Privacy Practices from Houston Dermatology Specialists which sets forth the ways in which my person health information may be used or disclosed by Houston Dermatology Specialists and outlines my rights with respect to such information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

(Parent/guardian authorizes and signs on behalf of \_\_\_\_\_ (name of minor)