Acknowledgement: Notice of Privacy Practices & Financial Responsibilities

I am a patient of Tarrant Dermatology. I hereby acknowledge receipt of Tarrant Dermatology's Notice of Privacy Practices and Notice of Financial Responsibilities.

____ ______________________
Patient's Name DOB

____ ______________________
Signature Date

OR, **if you are not the patient**:

I am the parent or legal guardian of the minor patient, __________________________________ (print patient's legal name). I hereby acknowledge receipt of Tarrant Dermatology's Notice of Privacy Practices and Notice of Financial Responsibilities with respect to the patient.

____ ☐ Parent ☐ Legal Guardian
Your Name

____ ______________________
Signature Date