ALTA VISTA DERMATOLOGY

206 W. County Line Rd., Suite 340
Highlands Ranch, CO 80129

Acknowledgment of Receipt of Notice of Privacy Practices, Office Policies, and Cancellation and No-Show Policies

This document acknowledges my receipt of the Cancellation and No-Show Policies, Office Policies and Notice of Privacy Practices that pertains to patient care at Alta Vista Dermatology. I have reviewed, understand and agree to the administrative rules, privacy, office and financial policies of Alta Vista Dermatology.

Notice of Privacy Practices: _____ (Initial)
Office Policies: _____ (Initial)
Cancellation and No-Show Policies: _____ (Initial)

_____
Patient Name (please print)

_____ _____
Signature of Patient or Legal Representative *Date*

_____
Relation to Patient

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Extended Authorization Option:

Please list any person such as your spouse, caretaker or other family member who you would like to authorize to have access to information related to your health, appointments or billing (information that is protected under State and Federal Law excluded):

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

_____ _____
Signature of Patient or Legal Representative *Date*