

**WRITTEN ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES**

As a patient of Bahr Dermatology, I hereby acknowledge receipt of or access to Bahr Dermatology's Notice of Privacy Practices.

Name _____ DOB _____
Please Print

Signature _____ Date _____

See below only if signing as a representative (guardian, guarantor, proxy, etc.) for the patient.

As a parent or personal representative of _____, I hereby
Patient Name
acknowledge receipt of or access to Bahr Dermatology's Notice of Privacy Practices with respect to this patient.

Name _____
Please Print

Relationship to Patient: Parent / Legal Guardian / Other: _____

Representative Signature _____ Date _____