NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

A.Thomas Bundy, MD, FAAD, FACMS
Emily K. Murphy, FNP-C
Meghan M. Maloney, MS, PA-C
Kristen Clark, PA-C

Hilton Head Dermatology Skin Cancer Center, P.A.
Laser & Skin Surgery Center, L.L.C.

15 Hospital Center Blvd.
Medical Quarters, Suite One
Hilton Head, SC 29926

Legacy Center
4 Okatie Center Blvd. South Ste 202
Okatie, S.C. 29909

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I am aware that your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is available in the reception area. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: