ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

Name of patient _____

The Dermatology Associates of McLean, Ltd. **NOTICE OF PRIVACY PRACTICES**, has been reviewed by the patient, guardian, or legal representative.

_____ _____

SIGNATURE PATIENT (IF PATIENT UNDER 18, PARENT OR LEGAL GUARDIAN) **DATE**

_____

PRINT NAME

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

The patient, guardian, or legal representative hereby authorizes Dermatology Associates of McLean to release Medical Information to the following Physicians and family members.

_____ _____

SIGNATURE PATIENT (IF PATIENT UNDER 18, PARENT OR LEGAL GUARDIAN) **DATE**

PHYSICIANS FAMILY MEMBERS

_____ _____

_____ _____

_____ _____

_____ _____