ACMS American College of Mohs Surgery

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

The signature below acknowledges that I, _____, have
Patient Name
read and/or received a copy of John D. Boyer, M.D.'s Notice of Privacy Practices.

_____
Patient or Guardian Signature

_____
Date

PATIENT CONTACT AUTHORIZATION

Due to the HIPAA Privacy Act, we are only authorized to contact the individuals listed below

You may:

☐ Contact me or leave a message at: _____ (Home #)
_____ (Work #)
_____ (cell/pager #)

☐ If I am unable to be reached, you may leave a message with:

_____
Name Relationship to Patient

_____
Name Relationship to Patient

_____ _____
Patient or Guardian Signature Date