

SUSANNE L. GEE, M.D., M.S.

Dermatology Cosmetic Surgery

**NOTICE OF PRIVACY PRACTICES –
ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record.

We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so in regard to your health care.

You may see your record or get more information about it by contacting any staff employed by Dr. Gee.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. If you wish a complete copy of this document, please ask the receptionist at the front desk.

By my signature below I acknowledge reading this form and the availability of the Notice of Privacy Practices.

Parent or legally authorized individual signature Date Time

Printed Name if signed on behalf of the patient Relationship
(Parent, guardian, representative)

_____ ***Received a copy of complete Notice of Privacy Practices***

_____ ***Chose not to receive a copy of complete Notice of Privacy Practices***

This form will be retained in your medical records.