Karimipour Dermatology
Darius J. Karimipour M.D., P.C.
HIPAA

I am a patient of Darius J. Karimipour, M.D., P.C.

I hereby acknowledge receipt of Darius J. Karimipour, M.D., P.C.'s Notice of Privacy Practices.

Name [please print]: ________________________

Signature: ________________________________

Date: ____________________________________

OR

I am a parent or legal guardian of ______________________ [patient name]. I hereby acknowledge receipt of Darius J. Karimipour, M.D., P.C.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: ________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _________________________________

Date: ____________________________________