

**SOLANO DERMATOLOGY ASSOCIATES**  
2290 SACRAMENTO STREET  
VALLEJO, CA 94590  
(707) 643-5785

**RECEIPT OF NOTICE OF PATIENT POLICIES AND PROCEDURES  
AND RECEIPT OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM.**

I, \_\_\_\_\_, have received a copy of Solano Dermatology Associates' Notice of  
Patient Name  
Patient Policies and Procedures and I am aware that the Notice of HIPAA rights are posted in the  
office and a personal copy is available to me at anytime.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date