Receipt of Notice of Privacy Practices
Written Acknowledgement Form

_____

MITCHELL A. KLINE M.D., P.C.
DERMATOLOGY/DERMATOLOGIC AND COSMETIC SURGERY

I am a patient of MITCHELL A. KLINE M.D., P.C. and have reviewed MITCHELL A. KLINE M.D., P.C.'s Notice of Privacy Practices. A copy of the notice is available upon request.

Name [please print]: JEFFREY EPSTEIN

Signature: _____

Date: JAN. 11, 2019

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of MITCHELL A. KLINE M.D., P.C Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

September 23, 2013