DermPartners

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its *Notice of privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of privacy practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restriction but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________ Relationship to Patient:_____________________

Signature: ________________________________ Date: ____________________________

COMMUNICATION AUTHORIZATION EXCEPTION

How would you like to be contacted by us?

PATIENT'S RIGHTS OF DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communication of health information be made by alternative means.

I, ___________________________ wish to be contacted in the following manner

(Please check all that apply):

Home ☐Ok to leave detailed message ☐Leave message with callback # only

Work ☐Ok to leave detailed message ☐Leave message with callback # only

Cell ☐Ok to leave detailed message ☐Leave message with callback # only

Email ☐Ok to email detailed message ☐Leave message with callback # only—Email address:________________________________

Written Communication ☐Ok to mail to home ☐Ok to fax to home ☐Ok to fax to work

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records.

☐Any person in my household ☐Except_________________________☐Other ______________

Are there any guidelines that you wish for us to follow regarding correspondence OTHER that what has been addressed on this form? If so please tell us:

Patient Signature: _________________________________ Date: _____________________

Office use only- I attempted to obtain the patients signature in acknowledgment on the Notice of Privacy Acknowledgment, but was unable to do so as documented below:
Date: _________ Initials: _______ Reason: ____________________________