Perfect Skin Dermatology

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NOTICE OF PRIVACY PRACTICES

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

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Our Practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. Our Notice of Privacy Practices is displayed both in our waiting room and on our website: www.perfectskinderm.com. ***You also have a right to receive a copy at any time upon request.***

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment, and health care operation. Perfect Skin Dermatology provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We may leave messages regarding your health and financial information on your voicemail or with the person answering the phone numbers you have provided us. This information includes but is not limited to: lab and biopsy results, appointment times and scheduling information, insurance co-payments, deductibles and patient responsibility. We may also return a phone call from you and leave the information that you have requested. If you wish to modify who we may speak with or where we can leave messages, please notify our office.

Please list how Perfect Skin can contact you:

Is it ok to leave messages on the home phone # you provided?	**YES**	**NO**
Is it ok to leave messages on the cell phone # you provided?	**YES**	**NO**
Is it ok to leave messages on the work phone # you provided?	**YES**	**NO**
Is it ok to e-mail you from your Patient Portal at the e-mail address you provided?	**YES**	**NO**

Please list the name(s), phone number(s) and relationship(s) below of anyone authorized to receive information. If the patient is a minor, then parents can receive any information regarding the patient. ***(Please Note: If you do not list anyone, we will be unable to discuss any aspect of the above mentioned with anyone other than yourself.)***

NAME:	RELATIONSHIP:	PHONE NUMBER:

☐ **I have received a copy of the Notice of Privacy Practices (HIPAA form)**

☐ **I was offered, but declined, a copy of the Notice of Privacy Practices (HIPAA form)**

Patient/Guardian Signature:	Printed Name:	Date: