Advanced Dermatology & Skin Surgery

HIPPA Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I also understand that this practice has the right to change its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Dermatology and Skin Surgery Privacy Officer at: 16 Medical Park Drive, Asheville, NC 28803.

●MAY WE CALL YOUR HOME OR OTHER ALTERNATIVE LOCATION AND LEAVE A MESSAGE IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT, AND HEALTHCARE OPORATIONS (TPO), SUCH AS APPT. REMINDERS, INSURANCE ITEMS AND ANY CALLS PERTAINING TO YOUR CLINICAL CARE, INCLUDING LABORATORY RESULTS AMONG OTHER.

☐**YES** ☐**NO** IF YES, ALTERNATE NUMBER:_____

●MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK?

☐**YES** ☐**NO**

●MAY WE MAIL TO YOUR HOME OR ALTERNATE LOCATION REGARDING APPOINTMENT REMINDERS/PATIENT STATEMENTS?

☐**YES** ☐**NO**

*Our office will mail benign results to the patient. These results are in the form of a postcard, addressed to the patient. Unless told otherwise, these results will be mailed to your home address. Please notify our office if you want these results mailed to an alternate address.

●DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS?

☐**YES** ☐**NO**

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

By signing this form, I hereby give my consent for Advanced Dermatology to use and disclose **protected health information** (PHI) about me to carry out **treatment, payment and healthcare operations** (TPO). I acknowledge that I have received or have been given the opportunity to receive a copy of the Advanced Dermatology & Skin Surgery Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Dermatology may decline to provide treatment to me.

PRINT PATIENT NAME:_____

SIGNATURE:_____DATE:_____

Note: This form does not authorize us to release actual medical records to you or your representative(s). An authorization for the release of medical records is available upon request. A signed authorization must be updated every 12 months.