Advanced Dermatology & Skin Surgery ASHEVILLE

HIPAA Notice of Privacy Practices Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 operations (TPO), such as appointment reminders, insurance items and any calls pertaining to your clinical care including lab results, among other. □**YES** □**NO**
If yes, please provide phone number:_____

●May we phone you at work and leave a message to call our office? □**YES** □**NO**
If yes, please provide phone number:_____

●May we mail appointment reminders/patient statements to your home or alternate address? □**YES** □**NO**
*Our office will mail benign lab 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 regarding your PHI? □**YES** □**NO**
If yes, please provide their name, phone number, and relationship to you.

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

Patient Information: I understand that I have the right to revoke this authorization at any time in writing. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned by signing.

Authorization Signature of patient:_____, or

Signature of Legal Guardian:_____(if patient is under 18 years of age)

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

Consent I hereby give my consent for Advanced Dermatology and Skin Surgery to use and disclose my protected health information (PHI) to carry our treatment, payment, and healthcare operations.

Signature of patient:_____ Print patient name:_____, or

Signature of Legal Guardian:_____ (if patient is under 18 years of age)