Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I hereby acknowledge that I have received a copy of North Dallas Dermatology Associates Notice of Privacy Practices. I have been given the opportunity to review, understand and consent to this practice's Notice of Privacy Practices as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

_____ _____

Printed Name of Patient *Date*

_____

Signature of Patient or Legal Representative (if applicable)

Relationship to Patient (*If applicable*)
- ☐ *Parent or guardian of unemancipated minor*
- ☐ *Court appointed guardian*
- ☐ *Executor or administrator of decedent's estate*
- ☐ *Power of attorney*

Authorization for Use and Verbal Disclosure of Protected Health Information

This is not a medical release form for Physicians – there is a different form for that request

I hereby authorize North Dallas Dermatology Associates to use and/or disclose my protected health information as described below to:

Name and relationship to recipient(s) (friends/family only – not physicians):

1._____ Relationship: _____ Phone #:_____
2._____ Relationship: _____ Phone #:_____
3._____ Relationship: _____ Phone #:_____

( ) All Medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
( ) Only the following type of information: _____
( ) DO NOT disclose any information on file other than to patient.

VALID ONE YEAR FROM DATE SIGNED.

_____ _____

Signature of Patient or Responsible Party *Date*

Consent for treatment of minor child

Please note that you may disregard the notice below if this does not pertain to the patient

I, being the parent or guardian of, _____ in my absence do hereby request and authorize North Dallas Dermatology Associates permission to administer care as necessary. I authorize the following person/persons to authorize medical treatment for my child by North Dallas Dermatology Associates.
I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing. VALID ONE YEAR FROM DATE SIGNED.

NAME OF PERSON ACCOMPANYING PATIENT
(Excludes parent/legal guardian)

Relationship to Patient

1._____ _____

2._____ _____

3._____ _____

Parent/Guardian name: _____ *Signature:* _____

Relationship to Child: _____ *Date:* _____