NAME: _____ DATE OF BIRTH: _____

TREASURE COAST DERMATOLOGY

Acknowledgement of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to provide you with our Notice of Privacy Practices which explains our privacy practices and how we may legally use and disclose your Protected Health Information (PHI). In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, protected health information can be released.

By signing below, I acknowledge that I have received a copy of the Treasure Coast Dermatology's Notice of Privacy Practices and have been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

_____ _____
Print Name Date

_____ _____
Signature of Recipient Date

FOR MINORS ONLY

I am a parent or legal guardian of _____. I hereby acknowledge receipt of Treasure Coast Dermatology's Notice of Privacy Practices with respect to the patient.

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Name (print): _____

_____ _____
Signature of Recipient Date

Please list below the authorized representative(s) that we may speak with about your health care. You may at any time, with written authorization, change or revoke this authorization. By completing this form, please be aware that you authorize the health care providers and staff of Treasure Coast Dermatology to discuss all your health care needs, billing issues, and questions with those listed below.

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

Name:_____ Date of Birth:_____ Relation:_____

_____ _____
Patient Signature Date