THREE RIVERS DERMATOLOGY

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HIPAA

(Health Insurance Portability and Accountability Act of 1996)

Revised Date 08-022-2013

I acknowledge I have received a copy of
Notice of Privacy Practices for Protected Health Information

Patient Name:_____Date of Birth:_____
(please print)

Patient Signature:_____Today's Date:_____

(if minor or in the event of patient's emergency condition, signature of person receiving for patient.)

Please check all that apply

❑ I give permission for my medical information to be left on voice mail.

I give permission for my medical information to be given or discussed with:

❑ No one other than myself

❑ Spouse_____ Phone:_____
Name (please print)

❑ Mother_____ Phone:_____
Name (please print)

❑ Father_____ Phone:_____
Name (please print)

❑ Children_____ Phone:_____
Name (please print)

❑ Caregiver_____ Phone:_____
Name (please print)

❑ Other_____ Phone:_____
Name (please print)