THREE RIVERS DERMATOLOGY

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HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

REVISED DATE 08/22/2013

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

_____**Date of Birth:**_____

Patient Name (please print)

_____**Today's Date:**_____

Patient Signature **(In the event of the 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 an answering machine.***

I give permission for my medical information to be given to 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(s)(please print)

☐ ***Caregiver***_____***Phone:***_____

Name (please print)

☐ ***Other***_____***Phone:***_____

Name (please print)