RIVERCHASE DERMATOLOGY
15051 S. TAMIAMI TRAIL, SUITE 203
FORT MYERS, FL 33908

HIPAA Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

MAY WE CALL YOUR HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:_____ Phone:_____ Relation: _____

Name:_____ Phone:_____ Relation: _____

Name:_____ Phone:_____ Relation: _____

OUR OFFICE WILL MAIL BENIGN 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.

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Riverchase Dermatology Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

SIGNATURE:_____ **DATE:**_____