CAROLINA DERMATOLOGY
OF GREENVILLE

Patient Name: _____

Date of Birth: _____

PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

The Summary of our Notice of Privacy Practices is posted in our main lobby. The complete Notice of Privacy Practices in also available in our main lobby for your review. If you would like to receive a copy of the Summary and complete Notice, we have one available for you at the front desk.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

We have found that the easiest way to identify persons who are inquiring about your information is for you to assign a security password to your account. Persons who call will be asked this password instead of your social security information. Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Carolina Dermatology, PA has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy

Signature: _____

This acknowledgement was signed by: _____

Printed Name – Patient or Representative: _____

Relationship to Patient (if other than patient): _____

Date: _____

In front of: _____
(Practice representative)

Carolina Dermatology, PA
920 Woodruff Road
Greenville, SC 29607
Phone: 864-233-6338
www.carolinaderm.com

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HIPAA AUTHORIZATION FORM

I authorize Carolina Dermatology, PA to use and disclose my protected health information (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____ Appointments _____ Restrictions _____ Medications _____Diagnosis

_____ Date of Visit _____Reason for visit _____Released from care

Entity or person(s) authorized to receive this information:

_____Camp _____Social Worker _____ School/Daycare/Preschool

_____Employer _____Family/Friends _____Parole Officer

_____Personal Representative's Employer

This PHI is being used or disclosed for the following purposes:

_____Verify return to work/school _____Work/School Excuse

_____To verify restrictions

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose PHI expires.

_____No longer in school _____Employment terminated

_____Released from Care _____ Child is no longer a minor

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

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