1115 W. Randol Mill Rd. : (817) 303-MOHS (6647)
Suite 200 : (817) 303-6651
Arlington, TX 76012 : www.dfwskinsurgery.com

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION

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.

May we leave a detailed message on your answering machine / voicemail?
☐ Yes ☐ No

May we call you at work and leave a message to call the office back?
☐ Yes ☐ No

May we send you a text (SMS) message, if available?
☐ Yes ☐ No

May we send you e-mail messages, including occasional newsletters and information about specials and exclusive promotions?
☐ Yes ☐ No

Do we have your permission to talk and allow access to your PHI to family members or other individuals?
☐ Yes ☐ No

If yes, please provide the name, phone number, and relationship of authorized individuals:

Name: ________________________ Phone: _________________ Relationship: _______________

Name: ________________________ Phone: _________________ Relationship: _______________

Name: ________________________ Phone: _________________ Relationship: _______________

By signing this form, I acknowledge that I have received a copy of the DFW Skin Surgery Center'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.

Patient or Guardian Signature: _____________________________________ Date: _____/_____/_____

Relationship (if other than patient): _________________________________