DFW Skin Surgery Center PLLC

1115 W. Randol Mill Rd
Suite 200
Arlington, TX 76012

2485 E. Southlake Blvd
Suite 200
Southlake, TX 76092

: (817) 303-MOHS (6647)
: (817) 303-6651
: www.dfwskinsurgery.com

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION

The Health Insurance Portability and Accountability Act (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 message on your answering machine/voicemail, such as appointment reminders?
□ Yes □ No
May we call your work number and leave a message to call the office back?
□ Yes □ No
May we send you text (SMS) messages, such as appointment reminders or occasional promotions?
□ Yes □ No
If yes, the cell phone number I authorize for texts is _____.
May we send you e-mail messages, including appointment reminders, occasional newsletters and information about specials and exclusive promotions?
□ Yes □ No
If yes, the email address I authorize for emails is _____.

Reminder: Keep information sent to us through text or email to the minimum necessary and encrypt emails and texts whenever possible, especially when sending PHI, as unencrypted communications may be intercepted in the process.

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: _____
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. I further agree that I understand the risks of unencrypted/non-secure communications and I will either use an encrypted text messaging app of the practice's choosing and utilize secure email tools for any communications involving PHI or I accept these risks and choose to utilize unencrypted/non-secure means of communications. A copy of this consent will be included in my chart for future reference.

Patient or Guardian Signature: _____ Date: _____/_____/_____
Relationship (if other than patient): _____