DFW Skin Surgery Center PLLC

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HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT & COMMUNICATION PREFERENCES

Patient Name: _____ **DOB:** _____

DFW Skin Surgery Center provides you with our Notice of Privacy Practices, which explains how we may use and disclose your protected health information (PHI) and describes your privacy rights. This form documents receipt of that notice and your communication preferences. Your choices below do not affect your right to treatment.

ROUTINE COMMUNICATION PREFERENCES

May we leave appointment or office-related messages on your voicemail? ○ Yes ○ No

May we call your work number and leave a message asking you to call the office? ○ Yes ○ No

May we send appointment reminders and other routine office-related messages by text (SMS)? ○ Yes ○ No

Cell phone for texts: _____

May we send appointment reminders and other routine office-related messages by email? ○ Yes ○ No

Email address: _____

Ordinary email and text messages may not be fully secure. If you select Yes above, you understand this risk and authorize us to use the selected method for routine communications. You may change these preferences at any time.

PEOPLE INVOLVED IN MY CARE OR PAYMENT FOR CARE

May we discuss PHI directly relevant to your care or payment with the people you list below? ○ Yes ○ No

If yes, please list the individuals you authorize us to speak with:

Name	Phone	Relationship

Listing someone here does not authorize release of your complete medical record. We will limit disclosures to information directly relevant to that person's involvement in your care or payment. A separate written authorization may be required for other disclosures.

ACKNOWLEDGEMENT

By signing below, I acknowledge that I received DFW Skin Surgery Center's Notice of Privacy Practices and had an opportunity to ask questions. I understand that this acknowledgment is not a blanket authorization to use or disclose my PHI beyond what is permitted by law. I also understand that I may change my communication preferences or the people listed above at any time.

Patient or Guardian Signature: _____ Date: _____

Relationship (if other than patient): _____