Patient Name:____________________________________ **Date of Birth:** _________________

HIPAA ACKNOWLEDGEMENT AND DESIGNATION

I. Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly; (2) obtain payment from designated third-party payers; and (3) conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by High Valley Dermatology of its Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and of my right to request a copy of that notice. I understand that High Valley Dermatology has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

II. Designation of Relatives, Close Friends or other Caregivers to Represent Me

I agree that the practice may disclose certain health information to a Personal Representative(s) of my choosing who is/are involved with my health care or payment relating to my health care. I understand the Physician Practice will disclose only information that is, in their professional judgment, directly relevant to the person's involvement with my health care or payment relating to my health care. I designate the following individual(s) for this purpose (if you do not wish to share your health information with your spouse or others, write "None"):

Name: ______________________________ Relationship:_________________ Phone:_______________

Name: ______________________________ Relationship:_________________ Phone:_______________

In the event I elect to comment about this business in any form of social media or related digital environment, I hereby grant this office permission to reply as appropriate.

I understand that I may revoke this authorization at any time by giving a written notice to the Privacy officer at this office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization.

______________________________ ________________________________ _________________

Signature (relationship if parent or guardian) Date