CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Authorization to Disclose Protected Health or Billing Information
Patient Record of Disclosures

Patient Name (Last, First, Middle)	Date of Birth	Date
Home Address	City/State/Zip	Last 4 numbers of SSN
Email Address	Home Phone ( )	Cell Phone ( )
Preferred Method of Contact (Select One) Home Address____ Email Address____ Home Phone Number____ Cell Phone Number____ Other (see below)____		

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was offered or provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood/understand the notice.

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Patient/Authorized Representative/Parent (PRINT) **Patient Birthdate** **Date**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Be advised that completing preliminary health and insurance questionnaires does not establish a physician patient relationship with this practice. An evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.
Please indicate the acceptable forms/types of disclosure.

Home/Cell Telephone
Leave message with detailed information
Message with call back number

Written Communication
Mail to my Home Address
Mail to my work/office address
FAX to this number _____

Work Telephone ( )
Leave message with detailed information
Message with call back number

Other _____

Authorization for Release of Information

I hereby authorize Carolinas Skin Center to disclose my individual medical information to the person(s) listed below. I understand this authorization is voluntary and will not expire however it may be revoked at any time by notifying Carolinas Skin Center in writing. Leave blank if you prefer not to share your medical information with anyone other than a medical provider or a pharmacy.

Person(s) allowed to receive my Medical Records	Relationship to Patient

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Patient/Authorized Representative/Parent (Signature) **Patient Birthdate** **Date**