

# Carolinas Skin Center

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

Patient Name (Last, First, Middle)	Date of Birth	Date
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### 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.

#### 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 and preferred method(s) of contact.**

Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Leave message with detailed information

Message with call back number

Work 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 \_\_\_\_\_

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


I AGREE TO TEXT MESSAGING FOR APPOINTMENT INFORMATION TO THE FOLLOWING NUMBER (Rates may apply) \_\_\_\_\_

Patient/Authorized Representative/Parent (Signature)

Patient Birthdate

Date