NORTHEAST TARRANT DERMATOLOGY, INC.

1733 Precinct Line Road Hurst, Texas 76054
PHONE (817) 281-SKIN (7546)

Patient's printed name:_____Patient's date of birth: _____

If a biopsy or lab is performed, you can leave results on my answering machine or voicemail (Please mark one).

☐ **NO** ☐ **YES**, Preferred Phone Number: _____

By signing below, I authorize Northeast Tarrant Dermatology to use and/or disclose any protected health information (PHI) to the following (i.e. spouse, caretaker, etc):

_____ _____
Name of person receiving information Relationship to Patient

_____ _____
Name of person receiving information Relationship to Patient

_____ _____
Name of person receiving information Relationship to Patient

Once my health information is given to the above listed person(s), I understand that it's possible that it may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the above address, attention: Privacy Manager.

Notice of Privacy Practices

[Acknowledgement of Review]

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or
Personal Representative:_____**Date:**_____

Printed Name of Patient or
Personal Representative:_____

Description of
Personal Representative's Authority_____