

NORTHEAST TARRANT DERMATOLOGY, INC.

1733 Precinct Line Rd Hurst, Texas 76054 (817) 281-SKIN

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.

Would you like to be emailed with any of our sales or promotions?

NO **YES,** Email address: _____

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 _____