NOVATO DERMATOLOGY

HIPAA Privacy Practices Notices

A copy of the entire HIPAA notice is available for you to read in our office.

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 be used to:

1. Conduct, plan and direct my treatment among the various healthcare providers who may be involved directly and indirectly.
2. Obtain payment from insurance companies.
3. Conduct normal healthcare operations such as quality assessments and physician certification.

In addition to the above I also consent to the following:

Please send me appointment reminders by (**please check one**):

Telephone / Voicemail _____ US Mail_____ (Fill out reminder card)

Messages may be left on my voicemail or answering machine regarding appointments, health information, or test results:

_____ yes _____ no

Messages may be with people answering the phone regarding appointments, health information, or test results if you are not available:

_____ yes _____ no

Acknowledgement of Receipt of HIPAA Privacy Practices Notices:

_____ _____

Signature of patient, parent or legal guardian Date

_____ _____

Print name of person who signed above Relation to patient