PIMA DERMATOLOGY

HIPAA Consent Form (please read and sign below)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and all subsequent revisions, I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I acknowledge that I have the right to read and review the full HIPAA privacy act before signing this consent and at any time during office hours.

Patient Full Name _____ **DOB:** _____ / _____ / _____
(please print) (Month) (Day) (Year)

Signature _____ Date _____

*If under age 18, name of Parent or Legal Guardian:*_____
(please print)

Form filled out by: ☐ Patient ☐ Legal Guardian: _____

Disclosure authorized to: ☐ Spouse ☐ Children

Name: _____ Phone Number: ( ) _____ - _____ Relationship: _____
Name: _____ Phone Number: ( ) _____ - _____ Relationship: _____
Name: _____ Phone Number: ( ) _____ - _____ Relationship: _____

Is it OK to leave a voicemail? ☐ Yes ☐ No

Advance Directive Policy Acknowledgement (please read and sign below)

You have the right to make legally binding decisions regarding your future health care. You also have the right to name someone else to make health care decisions for you. Pima Dermatology, P.C. does not require patients to make copies of their Advance Directive documents. However, if you choose to provide copies, they will be kept in your chart. More information about the Arizona Advance Directive Registry can be found at www. http://www.azsos.gov/adv_dir/.

I acknowledge that I have the right to receive information regarding the Advanced Directive Policy.

Patient Full Name _____ **DOB:** _____ / _____ / _____
(please print) (Month) (Day) (Year)

Signature _____ Date _____

*If under age 18, name of Parent or Legal Guardian:*_____