ClearSkin Dermatology
general · cosmetic · pediatric

Patient HIPAA Acknowledgement & Designation Disclosure Form

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that **ClearSkin Dermatology** has provided a copy of the Notice of Privacy Practices (NPP). I have read the NPP (or I had the opportunity to read it if I so choose). I understand my rights and was able to ask questions regarding my rights and received answers to my satisfaction, and I agree to its terms.

_____ _____ _____

Name of Patient *(Print)* Signature of Patient/Parent/Guardian Date

II. Designation of Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that ClearSkin Dermatology may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In this case, ClearSkin Dermatology will disclose only information to the persons listed below.

Print Name:_____ **Phone number:** _____

Print Name:_____ **Phone number:** _____

Print Name:_____ **Phone number:** _____

III. Request to Receive Confidential Communication by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that ClearSkin Dermatology make all communication to me by the alternative means that I have listed below. If no changes need to be made for communication, please print, sign and date below.

Home/Cell Telephone Number: **Email Communication:**

_____ _____

_____ _____ _____

Name of Patient *(Print)* Signature of Patient/Parent/Guardian Date