Mid Florida
DERMATOLOGY &
PLASTIC SURGERY

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

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

By subscribing my name below, I acknowledge that Mid Florida Dermatology & Plastic Surgery has provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

Name of Patient	Signature of Patient/Parent/Guardian	Date
_____	_____	_____

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

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Last four digits of his/her SSN or password (required):**_____
Print Name: _____ **Last four digits of his/her SSN or password (required):**_____
Print Name: _____ **Last four digits of his/her SSN or password (required):**_____

I,_____, acting on behalf of my minor son/daughter_____,
Parent/Guardian (print) **Name of Patient**
as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:

_____

☐ OK to leave message with detailed information
☐ Leave messaage with call back numbers only

Written Communication Address:

_____

☐ OK to mail to address listed above
☐ E-mail me at: _____

Work Telephone Number:

_____

___OK to leave message with detailed information
___Leave message with call back numbers only

Fax Communication:

_____

___OK to Fax at the number listed above

Other: _____

Name of Patient (Print)	Signature	Date
_____	_____	_____

Witness:_____ **Date:**_____