FORT WAYNE DERMATOLOGY CONSULTANTS INC | Fort Wayne Plastic Surgery & Aesthetics

Patient Name _____ Date of Birth _____

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Fort Wayne Dermatology Consultants, Inc. Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

Click here to read our Notice of Privacy Practices

Fort Wayne Dermatology Consultants, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

☐ **Accepted Notice**

_____
Signature of Patient

_____
Patient's Date of Birth

_____
Date

☐ **Declined Notice**

_____
Signature of Personal Representative

_____
Description of Personal Reps. Authority

I authorize the following person(s) minimal access (does not include copies of entire medical record) to my protected health information (PHI):

Name	**Date of Birth**	**Phone Number**	**Relationship**

Patient's signature: _____

For authorization to release limited PHI to the above listed individuals.