Melbourne Dermatology Center

Acknowledgement of Receipt of Notice of Privacy Practice

By my signature below I acknowledge that I have received Melbourne Dermatology Center's Notice of Privacy Practices.

Print Name: ______________________________________

Signature: ____

Date: _______________________

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

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Protected Health Information Release Form

In compliance with **HIPAA** regulations, and in order to facilitate requests for your protected health information, please complete the lower portion of this form.

I authorize the person(s) listed below to have access to any of my protected health information, including HIV, drug and alcohol abuse and psychiatric records. Melbourne Dermatology Center is permitted to share with them test results and information disclosed during my office visits. For copies of medical records, I understand that I will need to sign a separate authorization. Please list below, those individuals that you wish to receive your protected health information.

Full Name: _______________________________ **Relationship:** __________________________

Full Name: _______________________________ **Relationship:** __________________________

In addition to those individuals above, I request that you may also notify me of test results, appointment confirmations, and other information related to my health in the following manner:

____ Leaving messages on answering machine at: ___________________
____ Leaving messages on my work voicemail at: ___________________
____ Leaving messages on my pager at: ___________________
____ Leaving messages on my cell phone at: ___________________
____ Other forms of communication: ___________________

I understand that I will update Melbourne Dermatology Center with any changes in the above listed contact numbers. I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Print Name: ____________________________________ **Date:** __________________________

Patient Signature: _______________________________

Witness Name: _________________________________ **Date:** __________________________