Privacy Policies

Protected Health Information Release Authorization (optional)

I authorize Miller Family Dermatology to disclose my protected health information to the following person:

Name: ______________________________ Relationship: _________________ Can disclose info: __ Financial __Medical

Emergency Contact (circle one): Y / N If yes, phone number: ______________________________________

Additional Authorized Individuals:

Name: ______________________________ Relationship: _________________ Can disclose info: __ Financial __Medical

Name: ______________________________ Relationship: _________________ Can disclose info: __ Financial __Medical

Notice of Privacy Practices Written Acknowledgement

I have read a copy of Miller Family Dermatology's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Miller Family Dermatology has a link to the Notice of Privacy Practices on the practice website located at **http://millerfamilydermatology.com/HIPAA/**

Name (please print): ____ Date: ______________________

Signature of Responsible Party (Guarantor): ____

Relationship to Patient(s) (please check): ___ Self ___ Other: _____________ Witness Signature: ______________________

Note: The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.