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HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I acknowledge that I have the right to read and review the full HIPAA privacy act before signing this consent and at any time during office hours.

Signature _____

Date _____

Print Patient's Last Name _____

First _____

Advance Directive Policy Acknowledgement

Pima Dermatology, P.C. does not require patients to make copies of their living will or other advance directive documents. If you choose to provide us with a copy, it will be kept in your chart.

I acknowledge that I have the right to read and review an extended Advanced Directive Policy before signing this consent and at anytime during office hours.

Signature _____

Date _____

Print Patient's Last Name _____

First _____

UNDER 18 ONLY:

Guarantor/Parent Last Name: _____

First _____