INNOVATIVE DERMATOLOGY

HIPAA REGISTRATION

Patient: _____ DOB: _____

I acknowledge receipt of the Notice of Privacy Practices for Innovative Dermatology.

X_____ _____

Signature of patient/Responsible Party Date

_____

Printed Responsible Party Name/ Relationship to patient

Authorization for Contact Methods

I hereby give Innovative Dermatology my permission to contact me at all of the contact numbers and addresses provided to ADA in order to communicate my protected health information (or that of my child) including results, prescriptions and appointment information. This communication may be via US mail, phone, answering machine, texting on mobile phone, or emailing. Please list restrictions below:

_____

X _____ _____

Signature of patient/Responsible Party Date

Delegation of Patient Representative

By my signature below, I hereby authorize the disclosure of my Protected Health Information (PHI) (or that of my child), as well as appointments and billing information to be shared with the person(s) listed below.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

X_____ _____

Signature of patient/Responsible Party Date