

Colorado Springs Dermatology Clinic, P.C.

Notice of Privacy Practices – Patient Acknowledgement

We at Colorado Springs Dermatology Clinic are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Authorization Form

Patient Identification		
Patient Last Name:	First:	MI:

Date of Birth:	How would you like to be addressed?	

Order Preference

To assist us in protecting your privacy, please complete the following:

_____ Home Phone: _____

May we leave a voice mail message for you here? Y N

_____ Work Phone: _____

May we leave a voice mail message for you here? Y N

_____ Cell Phone: _____

May we leave a voice mail message for you here? Y N

Please list any family or other who may be involved in coordinating your care or payment for care. Also indicate what information may be shared with each individual.

Name	Phone Number	Relationship to Patient	Type of Information		
			All	Appts/Sched	Medical
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Emergency Contact	
Emergency contact: _____	Phone: _____
Relationship to Patient: _____	May we speak to this person regarding your care? <input type="checkbox"/> Yes <input type="checkbox"/> No

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

I have been made aware of the privacy policies of Colorado Springs Dermatology Clinic, P.C. that include Rocky Mountain Laser Center, P.C. and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signature of patient/Legal Representative: _____

Relationship to Patient: _____ Date: _____