



SOUTHLAKE DERMATOLOGY

1170 N. Carroll Ave. Southlake, TX 76092
www.SouthlakeDermatology.com
Main 817-251-6500 Fax 817-442-0550

PATIENT HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Practice may condition receipt of treatment upon the execution of this Authorization.
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease.

I acknowledge that I have read the above authorization and have had access to read Southlake Dermatology's NOPP.

Signature of patient/Legally authorized representative

Date

Print Name

If a legal representative: relationship to patient

Physician Assistant & Esthetician Information

This facility has on staff physician assistants and estheticians to assist in the delivery of medical dermatology care. A physician assistant "PA" is not a doctor but is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. I have read the above, and hereby consent to the services of a physician assistant for my healthcare needs. I understand that at any time I can request to see the physician.

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. The turnaround time for routine communications is 24 hours. The service provider may delay message delivery which is out of our control. Do not email us for urgent matters that require immediate attention. Communications related to diagnosis and treatment will be filed in your medical record. This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of the email, third parties may have access to messages. I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors. I understand and agree to the above email policy. By signing below, you are agreeing that we may send medical related correspondence and newsletters to you via email, and that we may respond to your emails to us via email.

I acknowledge that I have read the above and give my consent for email communications and use of physician assistants and estheticians in the management of my care.

Signature of patient/Legally authorized representative

Date

Print Name

If a legal representative: relationship to patient

MINOR PATIENTS (if applicable)

I give my permission for Southlake Dermatology to examine and treat _____,
my minor child, in your office without me being present. Child's DOB: _____

Parent or guardian name

Parent or guardian signature

Date

MEDICARE supplement: MEDIGAP RELEASE

For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to release any information to my Medigap carrier needed to determine benefits.

Signed (insured person) _____

Date _____