PiMA DERMATOLOGY

ADULT / PEDIATRIC / COSMETIC / LASER & SKIN SURGERY

HIPAA Consent Form (please read and sign below)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and all subsequent revisions, 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.

Patient Full Name ____ **DOB:** ______ / ______ / _______
(please print) (Month) (Day) (Year)

Signature ____ Date ____________________

*If under age 18, name of Parent or Legal Guardian:*____
(please print)

Advance Directive Policy Acknowledgement (please read and sign below)

You have the right to make legally binding decisions regarding your future health care. You also have the right to name someone else to make health care decisions for you. Pima Dermatology, P.C. does not require patients to make copies of their Advance Directive documents. However, if you choose to provide copies, they will be kept in your chart. More information about the Arizona Advance Directive Registry can be found at www. http://www.azsos.gov/adv_dir/

I acknowledge that I have the right to receive information regarding the Advanced Directive Policy.

Patient Full Name ____ **DOB:** ______ / ______ / _______
(please print) (Month) (Day) (Year)

Signature ____ Date ____________________

*If under age 18, name of Parent or Legal Guardian:*____