Privacy Statement

FAYETTE AREA DERMATOLOGY

You have the right to review our privacy note, request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Signing below signifies that you have had the opportunity to view our Notice of Privacy by requesting a copy or reading a copy located in the waiting room and you agreed to the privacy policy of our office.

By signing below, you acknowledge that you have read, understood, and agree to the Dermatology Financial Policy and our Notice of Privacy Practices.

Printed Patient Name: _____

Signature of Patient/Insured/Guardian: _____ Date:_____

Printed Name of Guardian: _____ Date:_____

Signature of Office Representative: _____ Date:_____

Please list the names of any person to whom we may disclose the patient's private health information and how the individual is related to the patient.

Name: _____ Phone #: _____

Relationship to Patient: _____ *Expiration Date: _____

Name: _____ Phone #: _____

Relationship to Patient: _____ *Expiration Date: _____

Name: _____ Phone #: _____

Relationship to Patient: _____ *Expiration Date: _____

*Expiration Date: Date the ability to disclose the patient's private health information expires. If there is no expiration date, please leave blank.