Pioneer Valley Dermatology, PC

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Acknowledgement of Notice of Privacy Practices

By signing this I acknowledge that I have an opportunity to review the **Notice of Privacy Practices** for Pioneer Valley Dermatology, which states that we will not disclose your Protected Health Information without your written permission. "Protected Health Information" (PHI) is information about you, including demographic information and even your name, that may identify you and that relates to your health and health care services. Your PHI may be used and disclosed to help in your treatment, to get payment for services provided to you, and as may be needed to operate this practice. I understand I may have my own personal copy of this notice if I ask for it, and that the current notice is available for review on Pioneer Valley Dermatology's web site, www.pioneervalleyderm.com.

Patient Name (print) _____

Patient Signature _____ Date: _____

Consent to Speak to or Release Information

If you want us to speak to anyone on your behalf you must complete the bottom half and date it so we have an expiration date for privacy protocol.

Due to HIPAA regulations we are unable to release medical information to anyone other than the patient. IF you would like us to be able to speak with anyone else regarding your medical care (biopsy reports, lab work, appointments, etc.), please indicate their name and relationship to you below.

This release will expire on (***must have a date, recommend future date***)

Expiration date: _____.

_____ _____

Name Date

_____ _____

Relationship to patient Your initials

_____ _____

Name Date

_____ _____

Relationship to patient Your initials

_____ _____