Song Dermatology Notice of Privacy Practices & Authorization Form

Effective Date: 07/01/2020

THE PATIENT NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE OF PRIVACY PRACTICES IS NOT AN AUTHORIZATION.

We are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. Alternatively, a copy is available on your website at songdermatology.com. If you would like a paper copy of the Notice, one can be provided to you. If you have any concerns with the Notice, please ask to speak to our Notice of Privacy Officer at 972-215-7855.

Authorization Regarding Communication (please check all that apply)

___I authorize receiving phone calls, leave detailed voice messages, or emails from Dr Song or one of her staff members as well as the billing company in relation to appointment reminders, healthcare information, test results, financial information and billing matters

___I authorize Song Dermatology to text me with appointment reminders. I can opt-out of texting at anytime by replying STOP to any text I receive.

Authorization to Release Information to Family Members

Many of our patients allow family members or other care-givers to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to provide this information without the patient's consent. If you with to have your medical information, test results, and/or financial information released to any family members or caretakers, you must sign this form. You have the right to revoke this consent

I authorize Song Dermatology to disclose my protected health information to:

1. Name: ____________________ Relation: _________________ Contact Number: _______________
2. Name: ____________________ Relation: _________________ Contact Number: _______________

Acknowledgement of Review of Notice of Privacy Practices: *I have reviewed this office's Notice of Privacy Practices (available on songdermatology.com), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.*

Please sign at the bottom to confirm your understanding.

Patient name: ___________________________

Patient (Guardian) signature:______________________Date:_________

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