RECEIPT OF NOTICE OF PRIVACY PRACTICES

Georgia Skin Specialists, P.C.

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals involved directly with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility, you will be required to fill out a separate form to request your records.

PATIENT NAME (please print): ____ DATE OF BIRTH: __________________

I hereby acknowledge the receipt of a copy of the Notice of Privacy Practices of Georgia Skin Specialists.

PATIENT SIGNATURE: ____ TODAY'S DATE: _______________________

OR

PATIENT REPRESENTATIVE'S NAME (please print): ____

RELATIONSHIP TO PATIENT: ☐ PARENT ☐ LEGAL GUARDIAN ☐ PERSON WITH POWER OF ATTORNEY

SIGNATURE: ____ TODAY'S DATE: _______________________

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

This form summarizes the anticipated use of information about you for which this authorization is required. Georgia Skin Specialists, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). By signing this authorization, I permit Georgia Skin Specialists, P.C. to use and/or disclose my protected health information (PHI) as outlined below.

Please check all that apply:

- ☐ Do not share my medical/account information with anyone but myself.
- ☐ You may leave a message at my primary phone number: ____
- ☐ You may share my medical/account information with: ____

  ____

  (Please list the full name and relationship of any and all individuals authorized, ex: spouse, parent (if over 18), sibling, friend, etc.)

Expiration date of this authorization: _____________________

(If "none" is selected as the expiration date of this authorization, it will be valid until it is revoked or changed in writing.)

TELEPHONE CONSUMER PROTECTION ACT (TCPA)

I agree that the facility, Georgia Skin Specialists or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message to any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

SIGNATURE: ____ TODAY'S DATE: _______________________