Housel Dermatology, P.C.

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Acknowledgment of
Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- **Treatment:** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- **Payment:** Obtain payment from third-party payers.
- **Operations:** Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that should I request a copy of Housel Dermatology, P.C.'s privacy practices containing a more complete description of the uses and disclosures of health information, one will be provided. I understand that this organization has the right to chance its Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I authorize Dr. Housel and/or his staff to discuss my medical condition, including laboratory findings with the following individuals:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient Printed Name: _____ Relationship to Patient: _____

Medical practice use only

If patient refuses to sign, a good faith effort was made to obtain the patient's or authorized representative's written acknowledgement of Privacy Practices. The reason the patient or authorized representative acknowledgment was not obtained is as follows:

_____

_____

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Documented by: _____ Date: _____