FORT WAYNE
DERMATOLOGY
CONSULTANTS INC

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Fort Wayne Dermatology Consultants, Inc. Notice of Privacy Practices has been offered to me. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have been offered the Notice of Privacy Practices or have declined the offer.

Fort Wayne Dermatology Consultants, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Accepted Notice | **Declined Notice**

______________________________ | ______________________________

Signature of Patient | Signature of Personal Representative

____________________ | ______________________________

Patients Date of Birth | Description of Personal Reps. Authority

____

Date

I authorize the following person(s) minimal access (does not include copies of entire medical record) to my protected health information (PHI):

Name	**Date of Birth**	**Home Phone Number**
______________________________	______________	____________________
______________________________	______________	____________________
______________________________	______________	____________________
______________________________	______________	____________________

Patient's signature: ____

For authorization to release limited PHI to the above listed individuals.

☐ I further authorize Fort Wayne Dermatology Consultants, Inc. to communicate with me electronically through e-mail at the following e-mail address:____. **I understand that this e-mail communication is not secured by encryption therefore is not considered a secured or private communication. Fort Wayne Dermatology Consultants, Inc. will not be held responsible for further disclosure of your information sent via unencrypted e-mail.**

Patient's signature: ____

For authorization of e-mail communications.

Medical History Form

Date:_____________________ MR#:_____________________________ Birth Date:____________________ Age_________

Last Name:______________________________First Name: ______________________Middle:_______

Preferred Pharmacy____

Medication	Dose	Route	Frequency

Do you have any medical allergies? Yes No

List Allergies:____

Concern	Location	Duration	Prior Treatments
1.			
2.			
3.			