Dermatology Associates
of Oakbrook Terrace

NOTICE OF PRIVACY ACKNOWLEDGEMENT FORM

On April 14, 2003, the Federal Government mandated a new law (HIPAA) to protect your personal and medical information or protected health information (PHI). Though we guard this information carefully, we need your written permission to release it to parties that may require PHI. These would include your pharmacy, insurance company, laboratories, hospitals, and the like. Be assured that we will not release any of your PHI without specific consent for that event. The doctors and staff of our office will not release, discuss, or otherwise misuse any of your PHI. This is a HIPAA compliant office and adheres to the guidelines of this law to ensure protection of your PHI.

It is our policy to leave voicemail messages regarding appointments and appropriate lab results. In the case of information that is more personal or results, we will speak personally with you. In the event that family members call for PHI, we will use our best discretion as to the release of such information.

I give permission to Dermatology Associates of Oakbrook Terrace and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.

☐ **YES** ☐ **NO**

Leave a message of normal test results on my home answering machine or with a specified family member.

☐ **YES** ☐ **NO**

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

____

Designated Person *Contact Number*

Dermatology Associates of Oakbrook Terrace may wish to share new products, discounts or service information directly with you, our patient. The information may be communicated via phone call, letter, or email. You have the right to Opt In or Opt Out of any marketing communications by checking your preference below. (You are able change to your decision at any time by notifying our office.)

☐ I wish to opt IN and receive marketing and other communications via email, phone call or letter.

Email address: ____

☐ I wish to opt OUT; I do not wish to receive marketing information.

I acknowledge and understand the Notice of Privacy Practices for the office of Dermatology Associates of Oak Brook Terrace:

Patient name: ___________________________________

Signature of patient/guardian:___________________________________

Date:_____/_____/______