PIEDMONT PLASTIC SURGERY & DERMATOLOGY
www.ppsd.com

MR#

DATE

PATIENT RECORD OF DISCLOSURE

Patient's Name_____ DOB ____/____/____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

NOTICE: By typing in your name on this form, you are (i) confirming that you are the party listed at the top of this form, and (ii) agreeing that your typed signature is the legal equivalent - and carries the same force and effect – of your written signature for this specific document. After signing electronically, you will have the option to print a fully executed copy of this form. You also have the right to: (1) sign the form in our office; (2) withdraw your electronic consent at any time through written notice to us; and (3) obtain a paper copy of this form.

I wish to be contacted in the following manner (check all that apply):

Phone _____ ◯ OK to leave message w/ detailed info ◯ Leave message w/ call back number only

Permission to disclose information form (Please check ONE of the boxes below.)

◯ I allow Piedmont Plastic Surgery & Dermatology to discuss my medical information with:
_____relationship _____
_____relationship _____

◯ I request that my medical information not be shared with anyone other than another medical provider or a pharmacy.

By signing this document, I agree to all of the above. NOTE: You will sign below when you come into the office.

Print Name_____ Signature_____ Date____/____/____

(If patient is under 18 years of age, a parent or legal guardian must sign.)