SPECTRUM
DERMATOLOGY OF SEATTLE

PRIVACY AND HIPAA

Legal Name _____ Date of Birth _____
Last First Middle

Spectrum Dermatology of Seattle has my permission to leave a message regarding medical and/or financial information on the following:

Primary Phone: _____ YES ___ NO ___

Alternate Phone: _____ YES ___ NO ___

Work Phone: _____ YES ___ NO ___

Email address: _____ YES ___ NO ___

I authorize the staff of Spectrum Dermatology of Seattle to discuss my medical and/or financial information with the following individuals as needed or as it pertains directly to my care. This authorization may only be amended in writing by completing an amendment form.

1. _____
   Name Relationship Phone Number

2. _____
   Name Relationship Phone Number

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your provider's office. Our Notice of Privacy Practice describes in detail how your health information may be used and disclosed and how you can access your information.
By my signature below, I acknowledge receipt of the Notice of Privacy Practices. _____ _____ _____ Patient or legally authorized individual signature Relationship Date

FOR OFFICE USE ONLY IF PATIENT REFUSES TO SIGN: I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

___ Patient Refused to sign ___ Communications barriers ___ Emergency situation

___ Other (explain) _____

Spectrum Office Employee Signature:_____ Date: _____