BALA DERMATOLOGY

Notice of Privacy Practice Patient Acknowledgement
Consent for Use and Disclosure

By signing below, I acknowledge that I have been provided the *Practice Notice of Privacy Practices*, which contains a detailed description of the uses and disclosure of my health information and I have been given the opportunity to read the Notice. I hereby authorize *Bala Dermatology* to obtain, use and disclose private health information about me to carry out treatment, healthcare operations and to secure payment of my insurance carrier (including Medicare, Blue Shield, Personal Choice, Aetna, Major Medical and all other private insurance carriers) I have the right to review the Notice of Practices prior to signing the consent. A copy of the Notice is available upon request. Further, I authorize my insurance carrier to make direct payment to *Bala Dermatology*.

By signing below, I acknowledge the Notice of Privacy Practices.

Patient Name: _____ **Date**: _____
(Print)

Patient Signature: _____

Patient Representative: _____ **Date**: _____

Relationship to patient: _____

For **Internal Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign: (please specify)
_____

Presented on: (date and time):_____
Presented by: (name and title):_____