NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Fairhaven Dermatology has a responsibility to protect the privacy of your healthcare information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints. We may change the Notice of Privacy Practices at any time, and you may contact our Office Manager / Privacy Officer at 360-656-6278 to obtain a current copy or to ask questions. You will also have the opportunity to review this Notice upon check-in for your appointment.

Do we have permission to leave a message on your voicemail regarding your medical condition and / or billing?

☐ Yes ☐ No

With whom is it okay to discuss your medical condition and / or billing? Please provide name and relationship.

Name:____________________ Relationship:_______________Phone:_______________
Name:____________________ Relationship:_______________Phone:_______________
Name:____________________ Relationship:_______________Phone:_______________

By my signature below, I agree that I have received the Notice of Privacy Practices of Fairhaven Dermatology. This form will be retained in your medical record.

____ ___________________________

Printed Name (of patient or legal guardian) Patient name if minor

____ ________________

Signature (of patient or legal guardian) Date

Office staff complete:

I have attempted to obtain the patient's signature, but was not able to obtain it for the reason(s) listed below:

Date: ____________ Staff initials: ________
Reason: ____