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"Excellence in Dermatology Care"

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PERMISSION AUTHORIZATION

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices, in compliance with HIPAA (Health Insurance Portability & Accountability Act) regulations.

I have read and understood my rights under HIPAA as provided to me by the office of Edward H. Stolar, M.D., P.C.

The following services are provided as a courtesy by our practice. I understand that by giving my permission for these services, I have in no way authorized the release of any confidential medical information. My signature below authorizes the office of Edward H. Stolar, M.D., P.C. to contact me for the following reasons:

Permission to call me at my home, office, or mobile to confirm or reschedule an appointment, to provide me with test results, or to return my message(s)

Permission to leave appointment reminders or appointment cancellation notifications on an answering machine/voicemail, or with a family member, secretary, or household employee

Permission to mail reminder postcards regarding appointments

Permission to leave "your test results were normal" on an answering machine

Patient Name: ____

Signature: ____

Date: ____

Witness: ________________________