HIPAA

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act (HIPAA). This law prohibits any staff member from Wesson Dermatology, P.C. from discussing appointments, medications, treatment plans, or test results with anyone other than the patient unless specified.

I understand that if I ever wish to revoke the right of a personal representative to access my health information on my behalf, I must notify Wesson Dermatology, P.C. in writing that the individual is no longer my representative. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

If you would like to permit someone to discuss your medical condition, biopsy results, and medications or confirm appointments, please indicate their name(s) below.

Name	Relationship
_____	_____
_____	_____
_____	_____

I permit Wesson Dermatology, P.C. to provide my health information, including access to biopsy results and billing information, to the above listed individuals on my behalf:

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices
Patient Acknowledge of Receipt of Notice

I hereby acknowledge that I have received and reviewed Wesson Dermatology, P.C. Notice of Privacy Practices.

Patient Printed Name: _____

Patient Signature: _____ Date: _____