REBECCA M. JONES, M.D.
DERMATOLOGY

NOTICE OF PRIVACY PRACTICES UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA), I have a certain right to privacy regarding my protected health. I understand that this information can and will be used to:
Plan and direct my treatment and follow-up among multiple healthcare providers that may be involved with my treatment directly and indirectly.
Conduct normal healthcare operations such as quality assessments.

I have received and understand the Notice of Privacy Practices containing a more complete description of the uses of my health information. I understand that Rebecca Jones, M.D. reserves the right to revise this notice at any time and that a current copy of this notice can be obtained upon request.
I understand that I may request in writing the Rebecca M. Jones M.D., restrict how my private information is used or disclosed. I also understand that Rebecca M. Jones M.D. is not required to agree to my requested restrictions, but if she does agree then Rebecca M. Jones is bound to abide by such restrictions.

**** Do we have permission to (check **YES** of **NO** below):

Leave messages on your answering machine regarding appointment? ____**Y**____**N**
Regarding biopsy/lab results ____**Y**____**N**
Call you at your place of employment ____**Y**____**N**
Discuss your condition with any household member ____**Y**____**N**

If **YES**, whom _____Relationship _____

PATIENT NAME _____

SIGNATURE _____

DATE _____

PARENT OR GUARDIAN SIGNATURE (if patient is under 18_____