DALLAS Skin Cancer Center

Frank C. Saporito, MD
Elizabeth Wilder, MD
411 N. Washington Ave, Ste 1200
Dallas, TX 75246
P (214) 396-5227
F (214) 396-5445

Excellence In Dermatology™ FELLOW

ACMS American College of Mohs Surgery

HIPAA PRIVACY PRACTICES

I,_____, understand and have been provided access to
Patient Name
the Patient Notice of Privacy Practices for Dallas Skin Cancer Center at http://dallasskincancer.com/wp-content/uploads/2016/11/HIPAA_Patient_Notice_of_Privacy_Practices.pdf. I understand that I may request a personal copy of this notice. I understand that Dallas Skin Cancer Center will use my personal and health care information to communicate with other health care professionals participating in my care and my insurance company for services provided.

I understand that it is the policy of Dallas Skin Care Center to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment of my claims, I would like the following person / people to have access to my Private Health Information (for example; spouse, child):

Name(s)	Date of Birth
1._____	_____
2._____	_____
3._____	_____

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that Dallas Skin Care Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my Protected Health Information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____
Signature of Patient (or Legal Representative) Date

MRN: _____(office use only)