

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that my health information may include information both created and received by Deschutes Dermatology Center, may be in the form of written, electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in my treatment, both directly and indirectly.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for partial and/or entire healthcare.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Deschutes Dermatology Center has the right to change its Notice of Privacy practices from time to time and that I may contact Deschutes Dermatology Center at any time to obtain a current copy of the Notice.

I understand that I may request in writing that Deschutes Dermatology Center restrict how my private information is disclosed to carry out treatment, payment or health care operations. I also understand Deschutes Dermatology Center is not required to agree to my requested restrictions.

Note: *I authorize Deschutes Dermatology Center to leave messages regarding pathology and lab results, schedule changes and medication information on a voicemail and/or answering machine.*

Patient Signature: _____ Date: _____

Parent/Guardian signature required for minor (less than 18 years of age)

Relation to patient other than self (circle): Parent Guardian

Printed Patient Name: _____ Date of Birth: _____

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