

Triad Dermatology
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336-768-2180

NOTICE OF PRIVACY PRACTICE AND PATIENT RELEASE OF INFORMATION

PART I

Our Notice of Privacy Practice provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

This practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patients or Patients' Representative Signature

___/___/___
Date

PART II

I authorize the release of my health information to the following for further medical need, insurance purposes or for my specified request.

Family Member

Spouse

Name

Parent(s)

Name

Other

Please Specify

Name

Relationship

Signature

___/___/___
Date

Witness

___/___/___

FOR OFFICE USE

Patient Name

___/___/___
Date of Birth

Account #