Aesthetic Dermatology and Cosmetic Surgery, Inc. [ADCS]
Jeffrey H. Binstock, MD & Associates

Patient Acknowledgement of Notice of Privacy Practices And Release of Medical Information

I hereby authorize ADCS to use and disclose my individually identifiable protected health information ("PHI") in the manner described below. I understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Please Read and Initial

_____I understand that a Notice of Privacy Practices is required by the federal privacy law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Revised 9/23/13), and is available for me to read in the office. I may request to receive a copy of this Notice now or via email.

_____I understand that ADCS staff will identify themselves as a doctor's office when confirming appointments, returning my calls, and for routine follow-up calls. ADCS may leave a message on my voice mail or with the person answering my phone, including normal test results.

My Medical Information can be discussed with:____Patient only_____Family Member_____Friend

Name:_____Relationship:_____Phone:_____

My Account/billing Information can be released to: __ Patient only___Family Member Friend_____Other:

Name:_____Relationship:_____Phone: _____

I give ADCS permission to send a thank you letter to the person who referred me:
□ Y □ N _____
Name

I give ADCS permission to communicate with me via my Email Address:
□ Y □ N _____
Email Address

_____ I understand the above information is effective immediately and shall remain in effect unless I complete, sign, and date a new Patient Acknowledgement of Privacy Practices form.

Patient Name:_____Date of Birth: _____
Print Name

Patient Signature:_____Date: _____

If not signed by patient, please indicate relationship: □ Parent if patient is under 18 yrs of age
□ Guardian or conservator of an incompetent patient
□ Beneficiary or personal representative of deceased patient

For office use only

We attempted to obtain written acknowledgement of receipt of our NOTICE of PRIVACY PRACTICES, but acknowledgement could not be obtained because:
_____Individual refused to sign
_____Communication barrier prohibited obtaining acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement

_____
PLEASE SPECIFY

_____Other _____
PLEASE SPECIFY

_____ _____
DATE AESTHETIC DERMATOLOGY EMPLOYEE –[PRINT NAME AND SIGN]