PEACHTREE DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

NOTICE OF PRIVACY PRACTICES

371 E Paces Ferry Rd NE, Ste 900
Atlanta, GA 30305
Tax ID 581089205

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Peachtree Dermatology Associates, PC (PDA) has given me the opportunity to read a detailed notice of their Privacy Practices.

(A copy is posted for the general public at the front desk, and online at www.peachtreedermatology.com under "About Us" and "Privacy Policy", or a printed copy can be made available upon request)

Patient / Guarantor Signature*: _____ Date: _____

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

If not signed, please provide a reason why the acknowledgement was not obtained:

_____

Witness (Staff) Signature: _____ Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from PDA to speak with the appointed person(s) listed below regarding my care or test results.

Name_____Phone _____

Relationship to Patient _____

Name_____Phone _____

Relationship to Patient _____

Is it OK to leave results or other health information on your voicemail? _____YES _____NO (Check One)

Patient / Guarantor Signature*: _____ Date: _____

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

PATIENT PORTAL CONSENT

While PDA takes reasonable precautions to protect your confidential health information, email is not a completely secure method of communication. Therefore, PDA strongly encourages the use of our secure patient portal to communicate electronically. PDA's Patient Portal allows patients to review and update their medical record, schedule appointments, access test results, and send private messages through encrypted transmission. We will generally use your email address to activate your patient portal access.

I give permission for PDA to enable my portal access. _____YES _____NO (Check One)

I confirm that my email address is _____@_____

Patient / Guarantor Signature*: _____ Date: _____

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.