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DERMATOLOGY

ASSOCIATES OF

SAN ANTONIO

Acknowledgment Form

I understand that as a part of my healthcare, Dermatology Associates of San Antonio originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a notice of Privacy Practices that provides a more complete description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that Dermatology Associates of San Antonio reserves the right to change its practices and to make the new provisions effective for all Protected Health Information maintained by them.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dermatology Associates of San Antonio is not required to agree to the restrictions requested. They will not use or disclosure your health information without your authorization, except as described in the Notice of Privacy Practices.

The records of Dermatology Associates of San Antonio may contain information created by another entity or provider. Dermatology Associates of San Antonio is not responsible for the information contained therein, including the accuracy, completeness, relevance, legibility, or lack thereof, of such incorporated records. When requesting medical records, patient expressly requests release of all records maintained by Dermatology Associates of San Antonio concerning the patient, including incorporated records. Patient acknowledges that Dermatology Associates of San Antonio has no and assumes no duty to the patient regarding the content of or omissions from such records.

Printed Name of Patient

Signature of Patient or Legal Representative

Signature of Practice Witness

Date Signed by Patient or Legal Representative

Date Signed by Practice Witness

Dermatology Associates of San Antonio was unable to obtain acknowledgment / consent because:

- Emergency
 Patient Non-Responsive
 Patient Confused / Disoriented
 Other-_____
 Patient Refused - Reason _____

April 14, 2003

Effective Date of the Notice of Privacy Practices