



COASTAL

DERMATOLOGY & SURGERY CENTER, P.A.

AUTHORIZATION

By signing this Authorization, you acknowledge the opportunity to review the Notice of Privacy Practices of Coastal Dermatology & Surgery Center, P.A. Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to take the time to read it in its entirety.

Our Notice of Privacy Practices is subject to change. Upon request, we will provide you with the most recently revised notice at your office visit.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

If you have any questions, please contact: Privacy Officer
Coastal Dermatology & Surgery Center, P.A.
2504 Delaney Avenue
Wilmington, NC 28403

I acknowledge I have reviewed the Notice of Privacy Practices of Coastal Dermatology and Surgery Center, P.A.

Patient's Name (print)	Patient's Signature	Date
Person Authorized to Sign for Patient	Relationship to Patient	Date
Additional Person(s) Authorized to Medical Records	Relationship to Patient	Date
Witness		Date

Inability to obtain acknowledgement

This section is to be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement and the reasons why the acknowledgement was not obtained.

Name of Staff Member _____ Date _____