112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Tri-City Dermatology, PLLC (the "Practice") is committed to using your health information responsibly. We have generated a *NOTICE OF PRIVACY PRACTICES* for your review detailing how your health information may be used and/or disclosed and how you can get access to it. A summary of our *NOTICE OF PRIVACY PRACTICES* is posted in our office and available on our website. The complete *NOTICE OF PRIVACY PRACTICES* is available upon request or on our website.

UNDERSTANDING YOUR PHI AND HOW WE MAY USE AND/OR DISCLOSE YOUR PHI

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") was established to maintain the security and confidentiality of Personal Health Information (PHI) obtained or created by us in any form. PHI is any information that relates to your past, present, or future physical or mental health, including treatment and payment. This record may contain information about your personal demographics, medical exam, diagnoses, test results, treatment, or other pertinent data. Your PHI may be disclosed to other health care professionals involved in your medical care, your insurance company, operations supporting the management of the practice, and for other relevant and necessary uses as described in our ***Notice of Privacy Practices***. Acknowledgment

If you wish for persons other than those released under normal operations as indicated in the ***NOTICE OF PRIVACY PRACTICES*** to receive confidential PHI that is protected by law, you must release them in writing. Please indicate on your patient registration form your spouse or other person(s) whom you wish to receive your PHI. You may choose not release information to anyone. You may also specify restrictions of what information is released to your listed individuals. Parents or guardians of minor children do not need to be released.

YOUR RIGHTS REGARDING YOUR PHI

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. If you believe that your privacy rights have been violated, please contact the Practice's HIPAA Compliance Officer. You may also file a complaint with the U.S. Department of Health and Human Services - Office for Civil Rights. There will be no retaliation for filing a complaint with either the Practice's HIPAA Compliance Officer or with the Office for Civil Rights. By signing this form, I acknowledge that Tri-City Dermatology has made available for my review the Practice's Notice of Privacy Practices.

The above stated Notice of Privacy Practices is available for review on our website or upon request from the front desk.

I acknowledge the Notice of Privacy Practices has been made available to me. I have reviewed and agree to all terms described within the Notice of Privacy Practices.

______________________________	______________________________
Patient Name	Parent/Guardian Name & Relationship (if other than patient)
______________________________	______________________________
Signature of Patient or Parent/Guardian	Date