CAPITAL DISTRICT DERMATOLOGY ASSOCIATES, P.C.

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HIPAA NOTICE

I **_____**, have been offered/given a copy of the HIPAA act as it pertains to the office of Capital District Dermatology Associates, P.C. I understand that they will not give out my personal information without prior written permission from me. If the patient is under the age of 18, a parent or guardian must sign.

Signed: _____ Date:_____

Relationship:_____

TO GIVE MY PERMISSION

I, _____, hereby give Capital District Dermatology Associates, P.C. permission to discuss any and **all** aspects of my treatment in this office with: _____

_____ Date:_____
Signature of patient

_____
Witnessed by