CAPITAL DISTRICT DERMATOLOGY ASSOCIATES, P.C.

Jerome C. Hill, M.D. **Andrew Larsen PA** **McKenzie Conroy NP**

450 Route 9W
Glenmont, NY 12077
Phone: (518) 434-8121 * Fax: (518) 426-0620

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