

## HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge this office's Notice of Privacy Practices, which explains how medical information about me may be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Personal Representative



\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

## Authorization Form for Release of Protected Health Information

By signing this form, I authorize Raleigh Skin Surgery Center, PLLC to disclose my protected health information to the parties listed below in case of emergency, or for any other reason. This information will remain active and in your file until you request in writing that it be changed. You may release my protected health information to the following person(s):

\_\_\_\_\_  
Print Name Relationship Phone

\_\_\_\_\_  
Print Name Relationship Phone

\_\_\_\_\_  
Print Name Relationship Phone

You have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:  
Laura Lineberger (919-390-0200).

