DIVINE
Dermatology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In connection with the medical services that I am receiving from Iconic Dermatology and Cosmetic Surgery and its medical staff, I hereby authorize Iconic Dermatology and Cosmetic Surgery, the above-named practitioner, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to: any third party payor covering the medical services of the patient; other health care professionals and institutions involved in the delivery of health care to the patient;The proponent of any legally sufficient subpoena, or in response to a court order; Employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services and payment for such services; Pharmacies; and As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

- The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by my provider.
- The photographs shall be taken by my practitioner or by a photographer approved by my physician.

When providing information to me, information may be transmitted to me by any or all of the following means:

1. Telephone messages on an answering machine
2. Primary email on file
3. Text message

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

I acknowledge that I have received a copy of the 'Notice of Privacy Practices' from Iconic Dermatology and Cosmetic Surgery. This Notice describes how Iconic Dermatology and Cosmetic Surgery may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

If you believe your privacy rights have been violated, it is your right to file a formal complaint with Iconic Dermatology and/or the U.S. Department of Health and Human Services.

For more information, please contact the U.S. Department of Health and Human Services at 1-800-368-1019.

This consent is valid from the date executed until revoked in writing by the patient

Please sign below.

Patient Name_____

Patient Signature (legal guardian)_____

Date_____

DIVINE
Dermatology