

# GASTON DERMATOLOGY CLINIC P.A.

1072 X-RAY DRIVE  
P. O. BOX 3598  
GASTONIA, NC 28054

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THE DOCTOR AND STAFF OF GASTON DERMATOLOGY CLINIC PA WANT YOU TO KNOW HOW WE WILL PROTECT YOUR PRIVATE HEALTH INFORMATION.

WHEN YOU VISIT OUR OFFICE, IT IS VERY IMPORTANT THAT YOU FEEL SAFE IN TELLING YOUR DOCTOR PERSONAL INFORMATION THAT MAY BE REQUIRED TO FULLY DIAGNOSE AND TREAT A PROBLEM. AS MEDICAL PROFESSIONALS, PLEASE BE ASSURED THAT OUR PRACTICE HAS ALWAYS HAD STRICT POLICIES AND PROCEDURES TO PROTECT THE CONFIDENTIALITY OF THE INFORMATION THAT YOU HAVE ENTRUSTED TO US. HOWEVER, ON APRIL 14, 2003, NEW REGULATIONS BECAME EFFECTIVE UNDER A FEDERAL LAW CALL THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA"). HIPAA REGULATIONS COVER PHYSICIANS AND ALL OTHER HEALTHCARE PROVIDERS, HEALTH INSURANCE COMPANIES AND THEIR CLAIMS PROCESSING STAFFS. IN GENERAL, HIPAA WAS ENACTED TO ESTABLISH NATIONAL STANDARDS TO:

GIVE PATIENTS MORE CONTROL OVER THEIR HEALTH INFORMATION;

SET BOUNDARIES FOR THE USE AND RELEASE OF HEALTH RECORDS;

ESTABLISH SAFEGUARDS THAT PHYSICIANS, HEALTH PLANS AND OTHER HEALTHCARE PROVIDERS MUST HAVE IN PLACE TO PROTECT THE PRIVACY OF HEALTH INFORMATION;

HOLD VIOLATORS ACCOUNTABLE, WITH CIVIL AND CRIMINAL PENALTIES; AND

TRY TO BALANCE NEED FOR INDIVIDUAL PRIVACY WITH REQUIREMENT FOR PUBLIC RESPONSIBILITY THAT REQUIRES DISCLOSURES TO PROTECT THE PUBLIC HEALTH.

THE HIPAA RULES REQUIRE THAT OUR PRACTICE PROVIDE ALL OF OUR PATIENTS THAT WE SEE AFTER APRIL 14, 2003 WITH A NOTICE OF PRIVACY PRACTICES. THE NOTICE DESCRIBES HOW THE MEDICAL INFORMATION WE RECEIVE FROM YOU MAY BE USED OR DISCLOSED BY OUR PRACTICE AND YOUR RIGHTS RELATED TO THE ACCESS TO THIS INFORMATION.

PLEASE SIGN BELOW THAT WE HAVE PROVIDED YOU WITH A COPY OF THE NOTICE OF PRIVACY PRACTICE TO REVIEW. YOU ARE ENTITLED TO A PERSONAL COPY OF THE NOTICE AT ANY TIME TO REVIEW AND KEEP FOR YOUR RECORDS. IF YOU HAVE ANY QUESTIONS ABOUT OUR NOTICE OF PRIVACY PRACTICES, PLEASE FEEL FREE TO CONTACT OUR PRIVACY OFFICER.

I ACKNOWLEDGE THAT I HAVE REVIEWED OR RECEIVED A COPY OF GASTON DERMATOLOGY CLINIC PA'S NOTICE OF PRIVACY PRACTICES AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

PATIENT NAME: \_\_\_\_\_  
(PLEASE PRINT)

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVES: \_\_\_\_\_

IF PERSONAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_