Jimmy D. Schmidt, M.D.
819 Peakwood Dr.
Houston, TX 77090

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

____ Conduct, plan, and direct my treatment and follow-up among the office of DermSurgery Associates/Jimmy D. Schmidt, M.D., and its employees.

____ Obtain payment from third- party payers

____ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given the opportunity to read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that DermSurgery Associates/Jimmy D. Schmidt, M.D has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of this notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand this office is not required to agree to my restrictions, but if they do agree then they are bound to abide by such.

Patient Name (Printed): _____

_____

Signature of patient (if minor, signature of parent/guardian)

Date: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Acknowledgement, but was unable to do so as documented below.

Date: _____ Initial: _____

Reason: _____