John Q. Binhlam, M.D., P.C.
Advanced Skin & Laser Center (ASLC)
1649 Westgate Circle, Suite 100, Brentwood, TN 37027
(T) 615-843-7546 (F) 615-777-3376

HIPAA AUTHORIZATION

Patient Name:_____DOB:_____/_____/_____

CHOOSE ONE:

☐ **I authorize Advanced Skin & Laser Center to release my medical and billing information to the individuals listed below.**

☐ **I DO NOT authorize Advanced Skin & Laser Center to release my medical and billing information to anyone other than myself.**

NAME OF DESIGNATED PERSON	RELATIONSHIP	PHONE
_____ Please Print	_____	_____
_____ Please Print	_____	_____
_____ Please Print	_____	_____

The HIPAA privacy rule permits health care providers to communicate with patients regarding their health care, Including protected health information (PHI) and billing information. This includes communication with the patient through mail, phone, fax or some other manner.

I understand that ASLC is permitted by the HIPAA privacy rule to leave information regarding my appointment, including the date and time, on any phone number provided. ASLC may request a return phone call to our office when speaking to any individual that answers the phone. If I only want confidential communication between ASLC and myself, I must provide written notice to ASLC on a form provided upon my request.

I understand that it is my responsibility to keep Advanced Skin & Laser Center informed of any changes to this information and that I may revoke this authorization at any time by written notice to ASLC on a form provided upon my request.

_____ _____
Signature of Patient or Personal Representative (Legal Guardian) Date

_____ _____
Print Name of Legal Guardian Date