



North Florida Dermatology Associates, P.A.

Board Certified in Dermatology and Dermatologic Surgery

Providers

- Frank E. Schiavone, M.D.
- Robert G. Brown, M.D.
- Leonard A. Shvartzman, M.D.
- Jonathan Kantor, M.D.
- Sonia Espinoza, M.D.
- Michelle Sanson, P.A.-C
- Randolph B. Mahoney, P.A.-C
- Alice Beard, P.A.-C

NORTH FLORIDA DERMATOLOGY ASSOCIATES, P.A. HIPPA SIGNATURE AND AUTHORIZATION FORM

As of April 14, 2003 the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has required us to provide you with our **Notice of Privacy Practices** which explains our privacy practices and how we may use and disclose your Protected Health Information (PHI) for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. For any other purpose we will notify the patient. Our office is dedicated to protecting the confidentiality of your Medical Records.

Our **Notice of Privacy Practices** also explains how the patient may obtain access and/or copies of their records, make specific requests pertaining to their records and the process to file a complaint if there are concerns about the privacy of their records.

We have posted **North Florida Dermatology Associates, P.A. Notice of Privacy Practices** in the Lobby for your review. It is important that you read this notice. You have the right to receive a paper copy of this notice. You may obtain a copy by asking our receptionist at your visit or by calling and asking us to mail you a copy.

Clinical Research Director

- Lisa Thomas, BS, CCRS

I have been given the opportunity to read the NFDA Notice of Privacy Practices and fully understand and accept the terms of this notice. A copy of this consent will be included in my chart for future reference.

Locations

Riverside
1551 Riverside Avenue
Jacksonville, FL 32204

Baptist Pavilion
836 Prudential Drive
Suite 1507
Jacksonville, FL 32207

Orange Park
1893 Kingsley Avenue
Suite A
Orange Park, FL 32073

Beaches
50 A1A North, Suite 103
Ponte Vedra Beach, FL 32082

St. Augustine
200 Southpark Boulevard
Suite 209
St. Augustine, FL 32086

Patient or Representative Signature Date Date of birth

___ I would like to specify as to other people who may fully participate in my health care needs on my behalf: Pick up prescriptions, make appointments, inquire about lab test results, etc.

Name of Individual (s) Relationship Date of Birth

Patient or Representative Signature Date Date of birth

_____ I would like to make further specifications regarding the use of my Protective Health Information (PHI).

