INTEGRATED
DERMATOLOGY

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HIPAA Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practice that allows the patient the opportunity to review
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this consent

Name of Patient:_____ Date:_____

Signature:_____ Relationship to patient:_____
(if other than patient)

HIPAA Release of Information

Messages regarding office appointment or health information related to my care may be left on:

☐Cell phone ☐Home phone ☐Work phone☐Email ☐Text message

It is okay to discuss my health information with:

_____

Preferred Pharmacy

Pharmacy Name _____

Address _____

City, State, Zip Code _____

Phone Number _____