UNIQUE
Dermatology & Wellness Center
WHERE BEAUTY & HEALTH MEET

HIPAA PATIENT CONSENT FORM

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. A copy of our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Unique Dermatology & Wellness Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent.
- Protected health information may be used for treatment through one of you current doctors, payment with your insurance company or healthcare operations within our office.
- Unique Dermatology & Wellness Center has a Notice of Privacy Practices that is available for review.
- Unique Dermatology & Wellness Center reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but Unique Dermatology & Wellness Center does not have to agree to these restrictions if, for example it interferes with payment, daily operations or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Unique Dermatology & Wellness Center may condition treatment upon the execution of this consent.
- You have the right to be notified of a protected health information breach
- Unique Dermatology & Wellness Center cannot sell your health information without your permission.
- Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

Patient (Print Name):_____ **Date:**_____

Patient (Signature):_____**Relationship to Patient:**_____

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Unique Dermatology & Wellness Centers Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign ☐ Patient unable to sign ☐

Other_____

Employee Name:_____

Date:_____