Siperstein Dermatology Group

# HIPAA Patient Consent Form

Our Notice or Privacy Practices provides information about how we use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing the 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 revoke this consent in writing signed by you. However such a revocation shall not affect any disclosure 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 that their protected health information may be disclosed or used for treatment, payment, or health care operations. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice. The practice reserves the right to change the Notice of Privacy practices. The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosure will then cease. The practice may condition receipt of treatment upon execution of this consent.

## Communication Authorization Exception - How would you like to be contacted by us?

PATIENT'S RIGHTS OF DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communication of health information to be made by alternative means. Communication with the practice using email, fax, and cell phone are not guaranteed to be secure or confidential. If these methods are initiated below, I waive the practice's obligation to ensure confidentiality. I also understand that email and fax are not appropriate means of communication for emergencies.

**I, _____, (patient's first and last name) approve leaving or sending detailed messages via:**

- ☐ Home Telephone
- ☐ Cell Phone/Text
- ☐ Work Telephone
- ☐ Email Address
- ☐ Mail to home address

**Patient's Date of Birth: _____**

**Health Care Proxy/Emergency Contact** (In the event that you can't make your own medical decisions):

**Name: _____ Phone Number: _____ Relation to Patient: _____**

**I allow the release of my health information to the following people: (please print names clearly)**

| **NAME** | **RELATIONSHIP** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Patient Name or Guardian Name (please print)** _____

**Signature** _____

**Guardians Relation to Patient** _____

**Date** _____

Office Use only: I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Acknowledgement, but was unable to do so as documented.
Date:_____ Initials: _____ Reason:_____