

**HIPAA CONSENT
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION (PHI)**

INNOVATIVE DERMATOLOGY

The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Notice of Privacy Practices provides information pertaining to the use and disclosure of protected health information (PHI). Innovative Dermatology complies with HIPAA guidelines in regards to patient treatment, payment, and healthcare operations. You have the right to review our Notice of Privacy Practices prior to signing this consent. Innovative Dermatology reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and health care operations. You have the right to revoke this consent by submitting a written request. However, such a revocation shall not affect any disclosures we have already made in compliance with your prior consent. Innovative Dermatology shall provide this form, which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) if requested.

The patient or patient guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The patient/guardian may request a copy of the Innovative Dermatology Notice of Privacy Practices.
- Innovative Dermatology reserves the right to change the Notice of Privacy Practices.
- The patient or guardian may revoke this consent in writing at any time and all future disclosures will then cease.

With my consent, Innovative Dermatology may call my home or other designated location and speak with me, or leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance related information, and information pertaining to patient clinical care, including laboratory results, ect.

With my consent, Innovative Dermatology may forward to a designated address, any items that assist the practice in carrying out TPO, such as patient statements, collection letters and any other correspondence or related material.

The Practice in not required to agree to my requested restrictions, but if an exception is made, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Innovative Dermatology may decline to provide treatment.

By signing this form, I am consenting to Innovative Dermatology's use and disclosure of patient's PHI to carry out TPO.

Patient's Name (print please)

Date

Signature of Patient or Legal Guardian

Relationship