HIPAA CONSENT

Acknowledgement of Notice of Privacy Practices

AESTHETIC & CLINICAL DERMATOLOGY ASSOCIATES

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 about how **Aesthetic & Clinical Dermatology Associates (ACDA)** may use and disclose protected health information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent. **ACDA** reserves the right to revise its Notice of Privacy Practices at anytime. 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 protected health information (PHI) about you for treatment, payment and health care operations (TPO). 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. **ACDA** provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- 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 Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

With my consent, **ACDA** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **ACDA** may mail to my home or other designated location any items that assist the practice in carrying out health care operations, such as patient statements, collection letters and any other correspondence or related material.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **ACDA's** use and disclosure of my PHI to carry out TPO.

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, **ACDA** may decline to provide treatment to me.

I authorize ACDA to release information to the following people:

Name:_____Phone:_____Name:_____Phone:_____

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name **Date**