Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

________________________________________

Patient name

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that Mid-Charlotte Dermatology may use or disclose my protected health information for treatment, payment or healthcare operation – which means for providing healthcare to me, the patient; handling billing and payment; and taking care of other healthcare operation. This may include releasing your name, phone number and/or email address for the purpose of contacting you regarding appointments and practice updates. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

Mid-Charlotte Dermatology has a detailed document called the **Notice of Privacy Practices**. It contains a more complete description of your rights to privacy and how we may use the disclose protected health information.

I understand that I have the right to read the ‘Notice’ before signing this agreement. If I ask, Mid-Charlotte Dermatology will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Mid-Charlotte Dermatology to use and disclose my protected health information to carry out treatment, payment, and healthcare operation. I have the right to revoke this consent in writing at any time, except to the extent that Mid-Charlotte Dermatology has taken action relying on this consent.

________________________________________

Signature (patient or legal custodian/representative) Date

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Relationship to patient is signed by another party

You may obtain a copy of our Notice of Privacy Practices at any time by contacting our front desk at: 704-367-9777.

EDITED 4/2018