Professional Dermatology Care (PDC)
HIPAA and PRIVACY Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. If you need to have a biopsy or surgical excision, we will call you with your results in a timely manner. All labs that will come to our office will come via the Internet.

You have the right to request that we restrict how your PHI is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. 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 in your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Upon signing this agreement, the patient understands that:

- Protected Health Information may be disclosed or used only for treatment, payment or health care operations
- Professional Dermatology Care has a Notice of Privacy Practices and 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 uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this consent at any time in writing and all future disclosures will then cease
- The Practice may condition receipt of treatment upon execution of this Consent
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Please Sign and Print your name below:

X _____ Date____/_____/_____

X _____ _____
(Relationship to patient)

Witness: _____ Date____/_____/_____
(Practice Representative)

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received or have access to a copy of PDC's Notice of Privacy Practices.

_____ Date ____/_____/_____
Signature of Patient or responsible party