Professional Dermatology Care (PDC)
HIPAA and PRIVACY Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are an email friendly practice but we assure you that our policy is to NEVER to disclose your personal email to ANYONE for ANY REASON. If you need to have a biopsy or surgical excision, we will email your results to you in a timely manner. If you do not agree to have emails sent regarding your pathology report then please let us know now and we will ensure that the pathologist faxes the report to our office instead. Otherwise, all labs will come to our office via the Internet. **If you agree, please initial here_____**

You have the right to request that we restrict how protected health information about you 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 protected health information 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.
- The Practice has a Notice of Privacy Practices and that the patient has had 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.

Please Sign and Print your name below:
X →_____Date____/_____/_____
Patient or Patient Representative

If other than patient (Relationship to patient)_____

Witness: _____Date____/_____/_____
Practice Representative

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____
Signature of Patient or responsible party **Date**

Updated January 2016