

## Professional Dermatology Care (PDC) HIPAA and PRIVACY Patient Consent Form 2024

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. *On April 26, 2024, the Biden-Harris Administration, through the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) published a Final Rule, entitled the HIPAA Privacy Rule to Support Reproductive Health Care Privacy. The Final Rule prohibits the use and disclosure of protected health information (PHI) when PHI it is sought to investigate or impose liability on individuals, health care providers, or others who seek, obtain, provide, or facilitate lawful reproductive health care, or to identify persons for such activities. It also requires us to obtain a signed attestation that certain requests (health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures about decedents to coroners and medical examiners) for PHI potentially related to reproductive health care are not for these prohibited purposes. We fully support reproductive health care privacy.*

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 for WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

:

X → \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient or Patient Representative have received or have access to a copy of PDC's Notice of Privacy Practices.

If other than patient (Relationship to patient) \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Practice Representative