Rocky Mountain
DERMATOLOGY

HIPAA Patient Consent Form

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. 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, and for other purposes as permitted or required by law. You have the right to revoke this Consent in writing; however, such a revocation shall not affect any disclosures we have already made in accordance with your prior Consent.

The patient understands that:

- The Practice has a Notice of Privacy Practices, and that you have had the opportunity to review this Notice.
- You have a right to request and inspect your Protected Health Information (PHI) in a designated record set or in a summary as composed by us. The Privacy Rule states our right to request payment for the provision of these materials.
- We may exchange information with other covered entities, such as your Primary Care Physician, to maintain your continuity of care.
- PHI may be disclosed to our Business Associates, such as our outside billing company, who are under the same legal obligation to protect your information.
- We will issue a letter notifying you upon discovery of a possible breach in the security of your PHI.

_____signed this Consent.
Printed Name of Patient or Representative

Relationship to Patient (if other than Patient) _____

_____
Signature of Patient or Representative Date