PATIENT HIPAA CONSENT FORM
DiPreta Dermatology-Brunswick, Camden, Jesup, MS&SCC
Revised: 9/20/13, 1/06/14, 6/19/14, 12/22/16, 12/29/2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Each patient, or guardian, will be requested to sign the HIPAA Privacy Consent Form prior to being seen.

OUR OBLIGATIONS -- We are required by law to:

- Maintain the privacy of protected health information (e.g. 18 items identifying "you")
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies YOU ("Health Information"). Except for the purposes described below for ***Treatment, Payment, and Health Care Operations***, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our full Notice before signing this summary Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. 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.

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 disclosures we have already made in reliance on your prior Consent. Edward DiPreta, MD, P.C. dba DiPreta Dermatology – Brunswick, Camden, Jesup, and Mohs Surgery & Skin Cancer Center (the "Practice") provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions about this summary notice or the full Notice of Privacy Practices posted in the office, please contact our **Privacy Officer or Practice Manager via phone at toll free (866) 403-3376.** ***EXCEPTION: If you have a POA or court order changing access by a parent or family member, please present a copy to check-in with this signed form.***

- **Protected health information may be disclosed or used for treatment, payment or health care operations**
- **Parents of minor patients, regardless of marital status, have parental access unless legal paperwork stipulates otherwise**
- **The Practice reminds patients about upcoming appointments via phone, text, voicemail, mail, and/or email.**
- **The Practice has a Notice of Privacy Practices posted and the patient has the opportunity to review this Notice**
- **The Practice reserves the right to change the Notice of Privacy Policies**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease**
- **I understand this practice uses ePrescribing, a federally mandated initiative, and it allows our providers to see important information such as drug interactions and your prescription history**
- **I understand this practice may share information with other providers related to a referral and/or continuity of care**

PERMISSION FOR DISCLOSURES: ***(please pick one)***

____ **1)** Only disclose my treatment and payment/account info to me.

____ **2)** You can also disclose my treatment and payment/account info to the following people listed in addition to me:

a) _____ - Relationship = _____
b) _____ - Relationship = _____
c) _____ - Relationship = _____

Please note that it is your responsibility to notify our practice in writing if you no longer desire to have your protected health information disclosed to a family member or friend that you have previously authorized and/or not listed as an exception.

Patient Name (printed): _____ Date of Birth: _____

Signature _____ Relationship if not pt _____ Date Updated: _____
(Patient or Guardian)

Staff Member Witness: _____ **Acct#:** _____