renew
dermatology
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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

_____ _____
PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information (PHI). I understand that I have a right to read the complete 'Notice' before signing this agreement. The most current notice is available in the waiting area. I understand that Renew Dermatology may use or disclose my PHI for treatment, payment or healthcare operations including but not limited to providing health care, appointment reminders, billing and payments and other health care operations. Unless required by law there will be no other uses and disclosures of this information without my authorization.

I authorize Renew Dermatology to contact me in the following manner in order to carry out treatment, payment and healthcare operations.

Telephone Communications (check all that apply): Home: _____ Mobile: _____ Work: _____

Electronic Communications (provide e-mail address that may be used): _____

I authorize Renew Dermatology to use and disclose my protected health information in communicating with family and friends listed below. This may include but is not limited to communications regarding appointments, billing and payment, treatment, prescriptions or other health information.

Name	Relationship	In person With Patient	By Phone
_____	_____	_____ (initial)	_____ (initial)
_____	_____	_____ (initial)	_____ (initial)
_____	_____	_____ (initial)	_____ (initial)

My signature below indicates that I have been given the chance to review Renew Dermatology's Notice of Privacy Practices. My signature means that I agree and allow Renew Dermatology to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke or change this consent in writing at any time, except to the extent that Renew Dermatology has taken action relying on this consent.

_____ _____
SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____
Relationship to Patient if signed by another party **DATE**