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Coastal Dermatology and cosmetic center

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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that my PHI can and will be used for treatment, Payment and health care operations.

I have been offered or received a copy of the Privacy Notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. Any material changes to the Notice will be promptly posted in the office or on the *Coastal Dermatology & Cosmetic Center*'s website. To receive a copy of the latest version of this Notice, I will contact the Privacy Officer at (401) 490-4514

I understand that I may request in writing that *Coastal Dermatology & Cosmetic Center* restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then *Coastal Dermatology & Cosmetic Center* may use or disclose my protected health information (PHI) to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my protected health information (PHI) to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

_____, _____
Patient's Name (Print) **DOB (mm/dd/yyyy)**

_____, _____
Signature (Patient or Legal Representative for Patient) **Date**

_____
Legal Representative's Relationship to Patient

By signing below, I hereby authorize *Coastal Dermatology & Cosmetic Center* to disclose my Protected Health Information to the following family members, friends and other representatives.

Name: _____ Relationship: _____Phone:_____

Name: _____ Relationship: _____Phone:_____

Patient/Legal Guardian Signature: _____ Date: _____