Warwick Office
215 Tollgate Rd, Suite 206A
Warwick, RI 02886
Phone: 401-490-4515 **Fax:** 401-217-2942

Coastal Dermatology
and cosmetic center

Cranston Office
750 Reservoir Ave
Cranston, RI 02910
Phone: 401-943-0761 **Fax:** 401-217-2942

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 undergone at Coastal Derm & Cosmetic Center, herein referred to as "The Practice." The Practice term is inclusive of the Coastal Derm Medispa.

Treatment: This includes the provision, coordination, or management of healthcare and related services by one or more health care providers. An example of this is a primary care doctor referring a patient to a specialist doctor.

Payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.

Health care operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standard policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

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 Practice's website. To receive a copy of the latest version of this Notice, I will contact the Privacy Officer at (401) 954-5468

I understand that I may request in writing that The Practice 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 The Practice may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

Review Response Permission: By signing this form, I give The Practice permission to respond to any online review I write about their establishment.
I understand that The Practice may respond to my reviews on platforms like Google, Facebook, Yelp, or any other site to thank me or help address any concerns. Their responses may imply that I am or was a patient by explaining steps taken based on my feedback.

This authorization gives The Practice permission to respond to my reviews while safeguarding my privacy rights under HIPAA regulations. No protected health information or personally identifiable details will be shared in review responses without my express written consent as outlined in my Patient Consent Form.

Summary: By signing this form, I understand and agree to the following:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice reserves the right to change the privacy policy as allowed by law.

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- The Practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this consent.
- The Practice may phone, email, or send a text to you to confirm an appointment.
- The Practice may leave a message on your answering machine at home or on your cell phone for your appointment.
- The Practice may respond to online reviews I have authored.

_____, _____
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 Derm & Cosmetic Center to disclose my Protected Health Information to the following family members, friends and other representatives.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Patient/Legal Guardian Signature: _____ Date: _____