Midlothian Dermatology

HIPAA Acknowledgment Form for Privacy Practices

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – Please read the following statements carefully.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is displayed in our waiting room. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain current changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Office Manager.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Privacy Officer, 2306 Robious Station Circle, Midlothian, Va. 23113.

PLEASE FILL OUT:

I, ____, have had the full opportunity to read and consider this Consent form and am giving my consent to your use and disclosure of my protected health information as described in the "Notice of Privacy Practices."

I allow the following people to discuss/receive information about me:

____

____

Do we have your permission to:

Leave a message on your home answering machine?	☐ Yes	☐ No
Leave a message on your cell phone voicemail?	☐ Yes	☐ No
Send you a reminder text message?	☐ Yes	☐ No
Leave a message at your work?	☐ Yes	☐ No
Send you E-Mail? Address:____________________________________	☐ Yes	☐ No

____ ______________________

Signature of Patient or Patient's Representative Date

If this Consent is signed by a representative on behalf of a patient, please complete the following:
Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

FOR OFFICE USE ONLY:

☐ Patient declined to sign. Reason, if known: ____