

HIPAA CONSENT FORM



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

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. Arizona Dermatology Group provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- Arizona Dermatology Group has a Notice of Privacy Practices at each office location and the patient has the opportunity to review and request a copy of the Notice at any time.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

This Consent was signed by:

Patient or Representative Signature

Date

Printed Patient Name

Date of Birth

Relationship to Patient (if other than patient): _____

Employee Witness Initials: _____