Bluegrass Dermatology
HIPAA (Health Insurance Portability and Accountability Act) Consent Form

Patient Name: _____ Date of Birth_____ Chart #_____

As required by the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

- I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has a copy of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information, and that I can obtain a copy per request.
- **Consent to Treat:** I hereby authorize examination and treatment by Bluegrass Dermatology. I authorize the release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries). I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

CONSENT: I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

- I understand that I may request restrictions on the uses and disclosure of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.
- I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.
- Is there anyone (i.e. spouse, parent, guardian or family member) you authorize us to share any medical information with, if you are not available? [ ] YES [ ] NO
    - If yes, please provide their name & contact information below:

      Name: _____ Relationship: _____

      Home Phone: _____ Cell Phone: _____

RESTRICTION REQUEST SECTION ***If you do NOT want the physicians or staff at Bluegrass Dermatology to leave test result; appointment; or billing/account information on your personal voicemail, please make note in the Restriction detail below.

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

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* If you are over 18 years of age and under your parent's insurance policy, please check the box: [ ]

Signature of Responsible Party: _____ Date: _____