Health Insurance Portability and Accountability Act

ACKNOWLEDGEMENT OR RECEEIPT OF NOTICE AND CONSET TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the acknowledgement and consent

This acknowledgement of notice and consent authorizes **Basin Dermatology** to use and disclose health information for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. **Basin Dermatology** has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Consent to Treatment. I voluntarily consent to receive medical and health care services provided by **Basin Dermatology**, employees and such associates, assistants, and other health care providers. I understand that such service may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or images may be made/recorded for treatment and payment purposes only.

I acknowledge that **Basin Dermatology** may use health information exchange systems to electronically transmit, receive and /or access my medical information which may include, but is not limited to, treatment, prescriptions, labs, medical and prescription history, and other health care information.

Please mark if you agree to accept artificial messages by:

Phone calls ☐ Yes ☐ No **Text Messages** ☐ Yes ☐ No **Emails** ☐ Yes ☐ No

Authorization Form For Release of Protected Health Information

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by patient, or an agent given medical power of attorney, your private health information and/or treatment will not be discussed.

By signing this form, I authorize you to use and disclose the protected health information described below.

The health information you may release subject to this authorization is as follows:

☐ All Medical ☐ All Financial ☐ Other: _____

release my protected health information to the following person(s)/entity:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Basin Dermatology Compliance Office: Tammy Rowell, 4214 Andrews Hwy, Ste 110, Midland, TX 79703 Telephone: 432-689-2491 Fax: 432-699-1158

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPPAA privacy regulations. I have reviewed **Basin Dermatology** Notice of Privacy Practices. **Basin Dermatology** is authorized to use and disclose health information about patient listed below for treatment, payment, and healthcare operations purpose consistent with its Notice of Privacy Practice. **The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. As a best practice policy for Basin Dermatology we require all forms to be updated annually.**

Patient Name_____ Date of Birth_____ Date_____

_____ _____ _____

Signature of Patient Signature of Personal Representative Relationship to patient

(Basin Dermatology policy we require all information forms be updated annually)