

**Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information**

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**Patient Name** **Date**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Atlanta West Dermatology and Surgery Center, PC may use or disclose my protected health information for ***treatment, payment or health care operations (TPO)*** which means for providing health care to me, the patient: handling billing and payment: and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Atlanta West Dermatology and Surgery Center, PC has a detailed document called the “Notice of Privacy Practices”. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the “Notice” before signing this agreement. If I ask, Atlanta West Dermatology and Surgery Center, PC will provide me with the most current “Notice of Privacy Practices”

My signature below indicates that I have been given the chance to review such copy of the “Notice of Privacy Practices”. My signature means that I agree to allow Atlanta West Dermatology and Surgery Center, PC to use and disclose my protected health information to carry out ***TPO.*** I have the right to revoke this consent in writing at any time, except to the extent that Atlanta West Dermatology and Surgery Center, PC has acted relying on this consent.

**DO WE HAVE YOUR PERMISSION TO: YES NO**

*Leave a message on home/cell phone? ⃝ ⃝*

*Leave a message on your voice mail at work? ⃝ ⃝*

*Discuss your medical care or account with anyone other than you? ⃝ ⃝*

*If yes, whom* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature Date**

**Patient or Legal Custodian/Authorized Representative**

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**Relationship to Patient**

You may obtain a copy of our “Notice of Privacy Practices”, including any revisions of our “Notice” at any time by contacting Atlanta West Dermatology and Surgery Center, PC. You may also obtain a copy by going to our website, www.atlantawestdermatology.com