Vienna Gibson, D.O.
PO Box 691
Murrells Inlet, SC 29576
(843) 651-4600
Seaside-dermatology.com

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **For treatment:** This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- **For payment:** This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.
- **For health care operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge a clear understanding of the Privacy Practices. I understand that Seaside Dermatology has the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that has been maintained by Seaside Dermatology. Any material changes to the Notice will be promptly posted in the office or on the Seaside Dermatology' website. I will be given a copy of the latest version of this Notice at my next visit or I can contact Seaside Dermatology at the address above.

I understand that I may request in writing that Seaside Dermatology restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then Seaside Dermatology may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

_____ _____

Patient's Name **DOB (mm/dd/yyyy)**

_____ _____

Signed (Patient or Legal Representative for Patient) **Date**

_____

Legal Representative's Relationship to Patient