Columbus Skin Surgery Center inc.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use & 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 by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use & disclosure of protected health information about you for treatment, payment & 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. The Practice provides this form to comply with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

The patient understands:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices & the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time & all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Below is a list of names that I authorize Columbus Skin Surgery Center to release medical information to. I understand that medical information will not be released to anyone except the names that appear below. (You do not need to list referring physicians.)

1. _____

2. _____

3. _____

I acknowledge I have been given the opportunity to receive a copy of the Privacy Practices for the Columbus Skin Surgery Center.

Columbus Skin Surgery Center may contact me at the following number(s):

Phone # (____)_____ (_____)_____ □ Detailed Information □ Limited Information

_____
Printed Name-Patient or Representative

_____ _____
Signature Date

Relationship to patient (if other than patient):_____