TRIBECA PARK DERMATOLOGY

## Privacy Consent

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 the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization's Privacy Officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

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

Patient name (please print) _____

Signature _____ Date _____

Relationship to patient _____