HIPAA: PATIENT CONSENT FORM: **Greater Des Moines Dermatology P.C. (Revised date 5/16)**

Our Notice of Privacy Practices provides information about how we may use and 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 to the best of our ability.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and 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 and Accountability Act of 1996 (HIPAA). You may need to seek care at another facility if you cannot agree to this consent as it is necessary for us to provide you with adequate care.

If you have insurance, you have agreed for them (insurer) to have a role in payment, treatment, and review of your care. This is a contract with you and your insurance. GDMD has no role in your insurance coverage policies and procedures. Failure to provide accurate information will result in patient billing. It is your responsibility to provide accurate insurance information to GDMD. Changes to insurance information should be changed immediately…Incorrect/false information will send all billing charges directly to the patient.

The patient understands that:

***** Protected health information may be disclosed or used for treatment, payment, or health care operations (TPO)
* The Practice has a Notice of Privacy Practices and that 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 and all future disclosures will then cease. As above, further care at our facility may not be possible if you do not agree to the terms of this consent.
* You, as the patient, must acknowledge to our staff if you are unable to sign this consent and this will be recorded. As is self-evident, **TPO (Treatment/Payment/Health Care Operations)** is essential to provide you care.
* Our practice assumes that you have signed this consent before evaluation or treatment has been given. Your care may need to be obtained at another facility if you are unwilling to allow for **TPO**.
* You have the right to request amending of your personal health information (PHI).
* You have the right to inspect your personal health information (PHI) for a $40 fee.
* Patient portal access is currently available through our certified EMR (www.eclinicalworks.com) for **free**! This is a great patient resource (patient portal).

1) http://www.hhs.gov/ocr/hipaa 2) http://www.hipaaguidelines101.com/hipaa-faq.htm
3) http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

This Consent was signed by: Patient Printed **Name**: _____

Signature: _____Relationship to Patient:(If not the patient)_____

***Email** for access to **patient portal**: _____

Other people allowed to talk to GDMD about your care:

1) 2)
3) 4)
5) 6)

DATE: _____/_____/_____