HIPAA/ELECTRONIC COMMUNICATION/DEMOGRAPHIC DISPOSITION CONSENT FORM

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. **By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operation. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We follow all HIPAA and HITECH guidelines regarding securing patient information.**

Please list the name(s), phone number(s) and relationship(s) below of anyone **authorized** to receive information regarding your financial and medical care besides the patient. If the patient is a minor, then parents can receive the information regarding the patient.

NAME	RELATIONSHIP	PHONE

□ I **REQUESTED** A COPY OF THE HIPAA POLICY.
□ I **DECLINED** A COPY OF THE HIPAA POLICY.

Electronic Communication Policy Acknowledgement and Agreement

I acknowledge by signing below that I understand that electronic (online) communication has risks, including possible risks not mentioned in the Electronic Communication Policy. I agree to abide by the policies described in the Electronic Communication Policy. I agree to use reasonable judgment regarding any messages I send or receive. The information sent or received includes but is not limited to lab and biopsy results, prescriptions, general and medical questions, appointment and procedure times, insurance copayments, coinsurance, deductibles, and patient responsibility. I do not have any unanswered questions about what this agreement covers.

□ I **RECEIVED** A COPY OF THE ELECTRONIC COMMUNICATION POLICY.
□ I **DECLINED** A COPY OF THE ELECTRONIC COMMUNICATION POLICY.

Check the box and list the correct information for the preferred method Primary Source of Contact:
□ Home Phone: _____
□ Cell Phone: _____
□ Work Phone: _____
□ Texting: _____
□ E-mail: _____

Notify a patient service representative to opt-out of receiving electronic communication via email, phone or text.

The information listed below is used to capture data for a core government objective. The data collected is used to determine demographic disposition for certain types of diseases. You have the right to decline to answer these questions.

Race: □ Declined
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ White
□ Another Race

Ethnic Group: □ Declined
□ Hispanic or Latino
□ **Not** Hispanic or Latino

Language: □ Declined
□ English
□ Spanish
□ _____

Print Patient Name **Print Name of Parent/Guardian/POA** **Print Relationship to Patient**

Consent Signature **Date**

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www.SkinCancerAndDerm.com