**A close-up of a logo

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**HIPAA**

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

• a basis for planning my care and treatment

• a means of communication among the health professionals who may contribute to my healthcare

• a source of information for applying my diagnosis and surgical information to my bill

• a means by which a third-party payer can verify that services billed were provided

• a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility’s notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

• I have the right to review this facility’s Notice of Information practices prior to signing this consent.

• This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I’ve provided if requested.

• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.

• I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

• It is this facility’s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange the minimum necessary Protected Health Information for each transaction.

1. CONSENT TO MEDICAL CARE: By my signature or electronic signature below, I authorize the physician and other health care providers of Mid Atlantic Skin Surgery Institute and their professional staff including medical assistants, to perform any medical diagnostic procedures including performing local anesthesia and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services at the offices of the Practice. If the patient is under the age of 18, I as the parent or legal guardian authorize the providers and the staff of the practice consent to perform medical examinations, diagnostic procedures and treatments.

2. RELEASE OF MEDICAL RECORD INFORMATION: I hereby authorize the Practice to disclose all or any part or the contents of the medical record of the patient named on this Patient Information form/Medical Records to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patients(s) or myself.

3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby request and authorize that all insurance benefits due and payable for medical services rendered to the patient(s) be paid directly to the Practice.

4. PRIVACY POLICY ACKNOWLEDGEMENT: I acknowledge that I have received a copy of the Notice of Privacy Practice.

5. FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a “non-covered” service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that if I fail to make such payments in accordance with the payment policies of the Practice, or in the event of default of my financial obligation to pay for services rendered, the Practice may terminate the “doctor-patient” relationship with the registered patient(s). Furthermore, in the event of my default on my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

6. HIV/HEPATITIS B OR C TESTING: I acknowledge that if the provision of healthcare services to the registered patients(s) exposes any healthcare provider to the patient’s body fluids in a manner which may transmit immunodeficiency virus or HIV or Hepatitis B or C viruses, then the patient shall be deemed to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person(s) exposed, as provided by law.

  7. CORRECT INFORMATION: The undersigned certifies that he/she has provided correct information on the patient registration form and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient’s parent or legal guardian, duly authorized to execute the above and to accept its terms if patient is of 18 years or younger.

Patient name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or responsible party if minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_