Central Missouri Dermatology & Mohs Skin Cancer Surgery

MRN: ____________________

DOB: ____________________

Consent to Use Protected Health Information

To provide for your healthcare, CENTRAL MISSOURI DERMATOLOGY collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so. Therefore, I, ______________________________(printed name of patient or personal representative), consent that Central Missouri Dermatology may use and request the health information of (check one) myself or (specify): ______________________________for the following purposes: (If signing as a personal representative, documentation of your legal right to do so must be provided.) 1. Treatment (to perform actions required to help diagnose, maintain, or improve health); 2. Payment (to obtain reimbursement from third party payers); 3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare). Central Missouri Dermatology has privacy practices that are summarized in our Notice of Privacy Practices for Protected Health Information ("Notice"). This Notice describes the use and disclosure of protected health information, patients' rights relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this Notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, Central Missouri Dermatology may decline to provide healthcare to me. The consent I am signing today covers this and all future healthcare activities performed for me by Central Missouri Dermatology with respect to treatment, payment, and operations. This consent replaces and supersedes any previous consents I may have signed with Central Missouri Dermatology for such use of my healthcare information. If I wish to revoke this consent, such a request must be made in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then Central Missouri Dermatology may discontinue taking care of me. Unless I object, my name and location may be disclosed to anyone asking for me by name. Unless I request otherwise, information about my health may be disclosed to other people involved in my healthcare (e.g. family members, personal representatives, those accompanying me for care, etc). Unless I object, my religious affiliation may be disclosed to members of the clergy. I have the right to request restrictions or limitations as to how my protected health information will be used to carry out treatment, payment, or healthcare operations. I understand that HIPAA does not require such requests to be accepted, but if restrictions are accepted, then they must be honored. I request the following restrictions to the use and/or disclosure of my health information: o NONE OR LIST BELOW:

Signature of Patient or Personal Representative: ______________________________Date: ____/_____/20___

(If signing as a personal representative, documentation of your legal right to do so must be provided.)

Witness: ______________________________Date: ______/______/20______

Assignments of Benefits and Authorizations to Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, an/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s) and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits for other related services.

Signature: ______________________________ Date: ______________________________

Medicare Patients Only: HIC # ________________________ Medical Insurer: ____________________

I request payment of authorized medical benefits be made to the above listed provider and also authorize any holder of medical information about me to release to the above named medigap insurer any information needed to determine benefits payable for services form this provider.

Signature: ______________________________ Date: ______________________________

To be completed by Physician

Printed Name: __________________Title: _______________Signature: ________________Date: _____/_____/20_____

Summary of Notice of Privacy Practices

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice. (That acknowledgment is on the first page of this document.) Your Rights as a Patient. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices. Use of Protected Health Information. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information. Disclosures of Protected Health Information Requiring Your Authorization. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below. Disclosures of Protected Health Information Not Requiring Your Authorization. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests. Communication to You of Confidential Information by Alternative Means. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address. Restrictions to Use and Disclosure. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal. Access to Protected Health Information. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial. Amendments to Medical Records. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record. Accounting of Disclosures of Protected Health Information. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization. Other Uses of Your Health Information. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices. How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.