

Shoreline Dermatology

HIPAA NOTICE AND ACKNOWLEDGMENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have reviewed the Notice Of Privacy Practices (NOPP); I was offered a copy of the NOPP for my file.

I was informed that I have a right to request the limitation of the use/disclosure of my protected health information for the purpose of treatment, payment, or health care operations. While Shoreline Dermatology is not required by law to grant my request, they have agreed that if they decide to grant the request, they will be bound by that agreement.

In consideration of the information given to me, I hereby consent to the use of disclosure of my Protected Health Information (PHI) for the purpose of Treatment, Payment and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

I give my consent for Shoreline Dermatology to contact me by calling my home or other designated locations in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment and Healthcare Operations.

I give my consent for the use of mail, email (secure or insecure) or text messaging to me or designated locations to assist Shoreline Dermatology in carrying out the desired activities of Treatment, Payment and Healthcare operations.

I understand that I have the right to revoke the consent in writing, except to the extent that Shoreline Dermatology has already used or disclosed the subject information.

Date

Signature of Patient