DCI Dermatology Clinic of Idaho

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, DERMATOLOGY CLINIC OF IDAHO may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to DERMATOLOGY CLINIC OF IDAHO Notice of Privacy Practices for a more complete description of such uses and disclosures. The practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DERMATOLOGY CLINIC OF IDAHO reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to DERMATOLOGY CLINIC OF IDAHO Privacy Officer.

With my consent, DERMATOLOGY CLINIC OF IDAHO may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and others.

With my consent, DERMATOLOGY CLINIC OF IDAHO may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements.

With my consent, DERMATOLOGY CLINIC OF IDAHO may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that DERMATOLOGY CLINIC OF IDAHO restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to DERMATOLOGY CLINIC OF IDAHO's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If l do not sign this consent, DERMATOLOGY CLINIC OF IDAHO may decline to provide treatment to me.

____ ________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

____

PATIENT'S NAME (PLEASE PRINT)