

## Affiliated Dermatologists of Virginia HIPAA Consent and Required Government Forms

<b>Name:</b>	<b>Date of Birth:</b>	<b>Chart #</b>
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Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. It contains a section on Patient Rights outlining your rights under the law. You have a right to view our Notice before signing this consent. The terms of our Notice may change. If so, you may obtain a copy by contacting our office.

You have a right to request that we restrict how your protected health information is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to such restriction but if we agree, we will honor that agreement.

By signing this form, you agree to our use and disclosure of your protected health information for treatment, payment and healthcare operations. You have a right to revoke this consent, in writing signed by you. Such a revocation will no affect any disclosures already made in reliance upon your prior consent. This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (or responsible party) understands that:

- Protected health information may be disclosed for purposes of treatment, payment and healthcare operations, or for other purposes permitted or required by law.
- The office has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- The office reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the office does not have to agree to the restrictions.
- The patient has the right to revoke this consent in writing and all future disclosures will then cease.
- We will obtain a separate authorization for “subsidized” disclosures, meaning disclosures involving products or services with respect to which the Practice receives remuneration from a third party.

\_\_\_\_\_  
Signature (Patient or Responsible Party)/Date     self     resp. party

\_\_\_\_\_  
Practice Representative/ Date

**Do you give permission to discuss your medical information with anyone else?     Yes     No    If yes:**

Name	Relationship	Telephone

**May we leave personal medical information on your voice mail/answering machine?     Yes     No**

**If yes, please provide the number we may use to leave the information: \_\_\_\_\_**

Recent government regulations require that patients be given the opportunity to self-declare their race, ethnicity and primary language. These categories are predefined by the Office of Management and Budget (OMB). Providing this information is voluntary and does not affect the coordination of your care. We understand this information is sensitive and we hope you will find our process as considerate and efficient as possible.

<input type="checkbox"/> African American or Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American or Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Patient Declined	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Patient Declined	<input type="checkbox"/> English <input type="checkbox"/> Chinese <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Patient Declined
<b>Race of Record</b>	<b>Ethnicity of Record</b>	<b>Language of Record</b>