DUNCAN DERMATOLOGY

1104 Adams St, Suite 201, St. Helena, CA 94574
Tel 707-967-0800 Fax 707-967-0870
www.DuncanDermatology.com

# HIPAA Privacy Notice

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent, I am authorizing you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices* which contains a more complete description of the uses and disclosures of my protected information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke and this consent is not affected.

Name of Patient or Patient's Representative (Please Print):

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Signature of Patient or Patient's Representative: Date:

_____ _____

Practice HIPAA Privacy Representative:

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