Johnston Office
1539 Atwood Ave, Suite 301
Johnston, RI 02919
Phone: 401-490-4515 **Fax:** 401-217-2942

Coastal Dermatology and cosmetic center

Cranston Office
750 Reservoir Ave
Cranston, RI 02910
Phone: 401-943-0761 **Fax:** 401-217-2942

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that my PHI can and will be used for treatment, Payment and health care operations.

Treatment: This includes the provision, coordination, or management of healthcare and related services by one or more health care providers. An example of this is a primary care doctor referring a patient to a specialist doctor.

Payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.

Health care operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standard policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been offered or received a copy of the Privacy Notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. Any material changes to the Notice will be promptly posted in the office or on the Coastal Derm & Cosmetic Center's website. To receive a copy of the latest version of this Notice, I will contact the Privacy Officer at (401) 954-5468

I understand that I may request in writing that Coastal Derm & Cosmetic Center restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then Coastal Derm & Cosmetic Center may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

_____, _____
Patient's Name (Print) **DOB (mm/dd/yyyy)**

_____, _____
Signature (Patient or Legal Representative for Patient) **Date**

_____
Legal Representative's Relationship to Patient

By signing below, I hereby authorize Coastal Derm & Cosmetic Center to disclose my Protected Health Information to the following family members, friends and other representatives.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Patient/Legal Guardian Signature: _____ Date: _____