

# PPD

Porter Premiere Dermatology  
& Surgery Center

## HIPPA Information and Consent Agreement

The Health Insurance and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. HIPPA provides rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov).

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, exam rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, Protective Health Information and other documents and information.

Patients will be reminded of their appointments via telephone, e-mail or U.S. mail. We may send you other communication informing you of changes to office policy and new technology that you might find valuable.

You understand and agree to inspection and review of documents which may include Protected Health Information by government agencies or insurance payers in normal performance of their duties.

You agrees to bring any concerns or complaints regarding privacy to the attention of the office manager or the physician.

Your confidential information will not be used for the purposes of marketing or advertising or products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

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## Consent Agreement

### **A Consent to the use and disclosure of Health Information for Treatment, Payment, or Health Operation.**

I, (Print Patient Name) \_\_\_\_\_, understand that as part of my healthcare, this practice originates and maintains health records describing my medical history, symptoms, examination, diagnosis, treatment, test results and any plan for future care and treatment. I understand that this information serves as:

- \* A basis for planning my care and treatment
- \* A means of communication among other health care professionals who contribute to my care
- \* A means by which a third-party payer can verify that the services billed were actually provided
- \* A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals
- \* A source of information for applying my diagnosis to my bill

I have been provided with a *Notice of Information Practices* that provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how any health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to Use or Disclosure of my health information:

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**I fully understand and accept/decline the terms of this consent  
(circle one)**

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**Signature of patient or legal  
Representative**

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**Date**

