PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM:

PATIENT NAME:_____ D.O.B._____/_____/_____

_____ (PATIENT INITIALS) **Release Information.** I hereby permit Massapequa Dermatology and the physicians/clinicians or other health professionals involved in the inpatient or outpatient care to release my Protected Health Information (PHI) for purposes of treatment, payment, or healthcare operation.

- Healthcare Information regarding a prior admission(s) at other healthcare facilities may be made available to subsequent healthcare admitting facilities to coordinate Patient Care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under workman's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carries for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information ; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends, Family and/or Healthcare Providers

I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings, and care decisions to the persons listed below:

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

_____ I DO NOT WISH TO HAVE MY MEDICAL INFORMATION RELEASED TO ANYONE.

PATIENT'S SIGNATURE:_____DATE:_____