



Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient name: _____

Date: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that I have certain Patient Rights regarding my protected health information.

I understand that Dermatology of New Mexico, LLC may use or disclose my protected health information for treatment, payment, or health care related operations which includes providing health care to me, the patient, handling billing and payment; and/or taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dermatology of New Mexico, LLC has a detailed document called the: Notice of Privacy Practices, which contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the Notice of Privacy Practices before signing this agreement.

If I ask, Dermatology of New Mexico, LLC will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review this copy of the Notice of Privacy Practices.

My signature means that I agree to allow Dermatology of New Mexico, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dermatology of New Mexico, LLC has taken action relying on this consent.

Signature (Patient or Legal Custodian/Authorized Representative)

Date

Relationship to Patient if signed by another party

Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Dermatology of New Mexico 610 Broadway BLVD NE, Albuquerque, New Mexico, 87102
Phone: 505.225.2500 Fax: 505.225.2025