HIPAA Consent to Use and Disclose Health Information

_____ _____ _____

Last Name, First Name, Middle Initial DOB Date

Name and relationship of person completing this form, if other than the patient.

Name_____ Relationship_____

Address_____

Emergency contact name_____ Number_____

Relationship to patient_____

On April 14, 2003, the new Federal Health Insurance Portability and Accountability Act (HIPAA) became effective. The purpose of HIPAA is to protect the confidentiality and security of identifying patient health information through a number of privacy standards. SCG Skin Rejuvenation will do everything in its power to abide by the HIPAA regulations while respecting the privacy of patient's names and medical information.

SCG Skin Rejuvenation conducts appointment reminders for patients via phone, email or mail. Patients choose their communication preferences in the Patient Information Packet. SCG Skin Rejuvenation also sends newsletters and special offers to patients.

SCG Skin Rejuvenation will refrain from using patient names as referrals without written consent from the patient. SCG Skin Rejuvenation will use their best efforts to keep your name and medical information confidential.

1. I understand the privacy of my health information is protected under State and Federal laws.
2. I acknowledge my right to receive and review a Notice of Privacy Practices.
3. I understand any restriction of this consent may result in the inability for SCG Skin Rejuvenation to continue treatment.
4. I give SCG Skin Rejuvenation permission to contact me via chosen communication method identified on my Patient Information Packet.

I have read and understand this HIPAA Compliance and Consent Form.

Patient Signature_____ Date_____

Patient Printed Name_____

Witness Signature_____ Date_____

Witness Printed Name_____

Refused to sign or obtain consent _____