TD TULLAHOMA DERMATOLOGY

1330 Cedar Lane, Suite 700
Tullahoma, Tn 37388
Ph. 931-455-7400
F: 931-455-6344

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

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

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:
• I have the right to review this facility's Notice of Information practices prior to signing this consent;
• This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
• I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
• I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
• It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Tullahoma Dermatology, PC complies with the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, I consent to the clinic's use and disclosure of protected health information for treatment, payment and health care operations. This also means that Tullahoma Dermatology, PC may not disclose information including medical diagnosis, test results or treatment plans to anyone other than myself, for example spouse, child over the age of 18, or any other relations without written consent. I understand that I have the right to privacy of my Protected Health information as maintain by Tullahoma Dermatology, PC. By my signature below, I certify I have read and understand my rights to the privacy of my Protected Health information as well as the terms and conditions of this notice.

Patient Signature: _____

Patients name (please print): _____ Date:_____/_____/_____