DERMATOLOGY CENTER OF ROCKLAND, P.C. Effective Date: Immediately

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is posted and a copy is available to you.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that is available to you):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices.

Patient Consent and Acknowledgment

Patient Name: ____ Date of Birth: __________________

I hereby acknowledge that I have had the right to review Dermatology Center of Rockland (the "Practice") Privacy Policy (the "Notice") prior to signing this Patient Consent and Acknowledgement and that I hereby agree to the terms set forth therein.

By signing this form,

(i) I hereby consent to the Practice calling the phone numbers designated by me below or provided by me to the Practice to provide appointment information, results, medical consults and other contact relating to my protected health information ("PHI"). I also consent to the Practice leaving me a message on any of the designated numbers below or provided by me to the Practice to provide appointment information, results, medical consults and other contact relating to my PHI.

(ii) I hereby consent to the Practice sending mail to any physical address I hereby provided to the Practice.

(iii) I hereby consent to the Practice e-mailing me at any email address provided below or provided by me to the Practice.

I understand I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent I understand that the Practice may decline to provide treatment to me.

Patient Signature: ____ Date: ___________________

Please Circle; Parent or Legal Guardian Signature: ________________________________ Date: _______________

Phone Number (s): Cell: __________________________________ Work/Other: ______________________________

Home: __________________________________ Email Address (es): ___________________________________

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To Be Completed By Covered Entity If Unable To Obtain Written Acknowledgement from Patient

On ___/ ___/ _____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because: [ ] Patient did not understand the request to sign the Written Acknowledgement
[ ] Patient declined to sign this Written Acknowledgement [ ] Other (specify): ____

*** Please be advised that patients are required to provide authorization for the Practice to communicate with anyone who will be financially responsible for their care.**

DERMATOLOGY CENTER OF ROCKLAND, P.C.

PATIENT COMMUNICATION FORM

A. **FRIENDS AND FAMILY.** It is the office policy of Dermatology Center of Rockland, P.C. **not to release confidential medical information regarding your treatment to family members or friends,** except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Name: ____ Relationship to Patient: __________________

Name: ____ Relationship to Patient: __________________

Name: ____ Relationship to Patient: __________________

B. **Alternative Communications**. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:____

____

PRINTED NAME____

Patient/Parent/Guardian Signature:____

Date: ___________________________________

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Legal Guardian Treatment Permission

As the legal guardian of _______________________________, I give permission to the Dermatology Center of Rockland, P.C. to treat the patient without my presence at the time of treatment.

_________________________	_________________________	_________________________	___/___/____
Signature of Legal Guardian	**Patient's Name (Please Print)**	**Print name of Legal Guardian**	**Date**

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FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
____	________	_______
____	________	_______
____	________	_______
____	________	_______
____	________	_______
____	________	_______

HIPAA RELATED PROVISIONS

USING THE PATIENT'S NAME IN THE WAITING ROOM

I __________________________ understand that, by signing the HIPAA form, I give permission to the staff of the Dermatology Center of Rockland, PC, to call my name in the waiting room when verifying my information or calling me back to the examination room.

____

PATIENT SIGNATURE **DATE**

____

PARENT/GUARDIAN SIGNATURE (IF APPLICABLE) **DATE**

LEAVING DETAILED MESSAGES ON TELEPHONE

In an effort to increase efficiency within the office, the Dermatology Center of Rockland, PC, would like to gain your permission to leave detailed information on your telephone if they must contact you for lab results, medication refills, or for other reasons.
Please check off your preference below:

_____ In the event that I am unavailable when the staff attempts to return my call, I give permission for the staff to leave a voicemail at my

______ Home Number (_ _ _) _ _ _ - _ _ _ _

______ Cell Number (_ _ _) _ _ _ - _ _ _ _

______ Other Number (_ _ _) _ _ _ - _ _ _ _

_____ I do not give permission to the Dermatology Center of Rockland, PC, to leave a voicemail on my telephone if I am unavailable when they attempt to contact me.

____

PATIENT SIGNATURE **DATE**

____

PARENT/GUARDIAN SIGNATURE (IF APPLICABLE) **DATE**