HIPAA CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 **(HIPPA)** and this Consent by Coast Dermatology & Skin Cancer Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Coast Dermatology & Skin Cancer Center. I understand that diagnosis or treatment of me by J. Gregory Neily, D.O. and/or his assigns may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out permanent treatment, payment or the healthcare operations of Coast Dermatology & Skin Cancer Center. Coast Dermatology & Skin Cancer Center is not required to agree to any restriction that I may request. If, however, Coast Dermatology & Skin Cancer Center agrees to any restriction by me, such restriction shall be binding on Coast Dermatology & Skin Cancer Center and J. Gregory Neily, D.O. I further understand that I have the right to revoke this consent in writing, at any time, except to the extent that Coast Dermatology & Skin Cancer Center has taken action in reliance on this consent.

I understand I have a right to review Coast Dermatology & Skin Cancer Center's Notice of Privacy Practices prior to signing this Consent. Coast Dermatology & Skin Cancer Center's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Coast Dermatology & Skin Cancer Center duties with respect to my protected health information.

Please also note that as provided in Coast Dermatology & Skin Cancer Center's Notice of Privacy Practices, Coast Dermatology & Skin Cancer Center reserves the right to change the privacy practices that described in such notice. I may obtain a revised Notice of Privacy Practices by accessing the Coast Dermatology & Skin Cancer Center's website, calling the office (941) 493-7400 and requesting a revised copy be sent in the mail or asking for one at the time of the next appointment.

I ____DO ____DO NOT authorize Coast Dermatology & Skin Cancer Center to leave a message either on my answering machine or with the person who may answer my phone about appointments, billing questions, biopsy/lab reports, prescription information or other information as needed.

_____

Signature of Patient of Personal Representative Date