Newport Dermatology & Laser Associates

Medical Record #______________________

HIPAA (Health Information Portability and Accountability Act of 1996)

All new patients are presented with a copy of our Notice of Privacy Practices, a copy of which is being made available to you herewith. If you have questions and would like additional information, you may contact the Compliance Officer at (702) 360-3955. If you believe your privacy rights have been violated, you can file a complaint with the Patient Complaints Department at (800) 574-4196 or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Patient Complaints Department or the Office for Civil Rights. The address for the Office of Civil Rights is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201. Please allow those listed below access to my Protected Health Information (PHI):

Name:____ Relationship:_______________

Name:____ Relationship:_______________

Name:____ Relationship:_______________

PREFERRED METHOD OF COMMUNICATION

☐ Home Phone_________________________________ ☐ Cell____________________________________

****Okay to leave voice messages** ☐ Yes ☐ No Initial/Date____________________**

☐ Email Address______________________________________ **Initial/Date____________________**

CONSENT TO DOWNLOAD MEDICATIONS via SURESCRIPTS

This Consent is prepared in consideration to the requirement of the Health Information Portability and Accountability Act of 1996 (P.O. 104-91), 42 U.S.C. Section 13020d, and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA"). This Consent affects your rights in the privacy of your Personal Health Care Information (PHI). Please read carefully before signing. For your convenience and to expedite the process with your selected pharmacy, our office has the option to send your medications via electronic means (Surescripts). This Consent authorizes and covers any and all previous (refills) and future medication history and date that may include the pharmacy, notes, and prescribing physicians as well as other fields based upon availability. By signing this Consent, you are agree that West Dermatology/Las Vegas Skin and Cancer Clinics/North Coast Dermatology/English Dermatology/Cosmetic Laser Dermatology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to West Dermatology/Las Vegas Skin and Cancer Clinics/North Coast Dermatology/English Dermatology/Cosmetic Laser Dermatology to enroll me in the ePrescribing Program. I have had a chance to ask questions and all of my questions have been answered to my satisfaction. If there are any changes to the above information, I understand that I am responsible to contact this office to make the necessary changes in my patient files.

____ ___________________________

Print Patient Name Date of Birth

____ ___________________________

Signature of Patient or Responsible Party & Relationship Date