COUNTRYSIDE DERMATOLOGY & LASER CENTER, Inc.

Susan S. Roper, M.D.

2467 Enterprise Rd., Suite A, Clearwater, FL 33763

(727) 791-1411

NOTICE OF PRIVACY PRACTICES

This **condensed** notice describes how medical information about you may be used and disclosed, and how you can access this information. **A complete notice can be obtained by asking the receptionist.** This notice applies to all of your records generated by this practice, whether made by the practice or an associated facility. The practice provided this Notice to comply with the Privacy Regulations issues by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Law requires us:

1. Make sure that the protected health information about you is kept private.
2. Provide you with a notice of our privacy practices and your legal rights with respect to protected health information about you; and
3. Follow the conditions of the Notice that is currently in effect

We may use and disclose medical information about you for:

1. Treatment - if your family doctor has referred you for evaluation, we send your doctor a report of our findings.
2. Payment – in processing insurance claims, your personal information along with a diagnosis must be used to file a claim.
3. Health care operations – your insurance carrier sometimes require access to your protected health information prior to paying a claim.
4. Appointment and patient recall reminders – we use a sign in sheet at the reception desk, and we may disclose medical information to contact you as a reminder of an appointment for medical care, insurance items and any calls pertaining to your clinical care, including laboratory results among others. This contact may be in writing, phone, may entail leaving a message on an answering machine, which could (potentially) be received by others.
5. Emergency situations – we may disclose medical information to an organization that will assist in disaster relief effort or in an emergency situation, so that your family can be notified about your condition, status and location.
6. Research – we would obtain a written authorization from you before using your medical information for research.
7. Required by law – we will disclose information about you when required to do so by federal, state or local law.
8. Avert a serious threat to health safety – the only time we would disclose information would be to someone able to help prevent a threat to you.
9. Organ and Tissue Donation – we may release information to facilitate organ or tissue donation and transplantation.
10. Workers compensation – we may release information about you for worker's compensation or similar programs.
11. Public health risk – law or public policy may require us to disclose medical information about you for public health activities.
12. Investigation and Government activities – we may disclose medical information to local, state, or federal agencies for activities authorized by law.
13. Lawsuits and disputes – if you are involved in a lawsuit or dispute we may disclose medical information about you in response to a court or administrative order.
14. Law enforcement – we may release information if asked to do so by a law enforcement official.
15. Coroners – this may be necessary, to identify a deceased person or determine the cause of death.
16. Inmates – we may release information about you to the correctional institution or law enforcement official.

CHANGES TO THIS NOTICE – we reserve the right to change this notice at any time.

COMPLAINTS – if you believe your rights have been violated you can file a complaint with the practice, please contact the office manager in writing. All complaints will be investigated without repercussion to you.

PATIENT RIGHTS – You have the following rights regarding medical information we maintain about you.

1. The right to inspect and copy your chart
2. The right to amend your medical information in your chart
3. The right to an accounting of disclosures
4. The right to request restrictions or limitations of medical information that we use or disclose.
5. The right to a copy of this notice.

In the space below please list those you will allow us to share your medical information with, for example over the telephone or in person. Please note you can also choose to select, "RELEASE TO NO-ONE, OTHER THAN SELF"

Name of PERSON	RELATIONSHIP TO YOU

□ RELEASE TO NO ONE, OTHER THAN SELF

By signing this form, I am consenting to Countryside Dermatology & Laser Center, Inc's use and disclosure of my medical information to carry out treatment, payment and operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, or later revoke it, Countryside Dermatology & Laser Center, Inc. may decline to provide treatment to me. I acknowledge that I have been offered a copy and received if requested, a copy of Countryside Dermatology & Laser Center, Inc's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient of Legal Guardian

MARKETING CONSENT FORM

PLEASE READ AND SIGN OR DECLINE IF YOU WISH TO RECEIVE INFORMATION REGARDING NEW SERVICES.

I understand that Countryside Dermatology & Laser Center may occasionally be offering special promotions, events, discounts or announcements of new cosmetic treatments, services or products that I may find interesting.

My signature below gives permission for Countryside Dermatology & Laser Center to send me, at the mailing address or email address that I have provided on my registration form, any such announcements at their discretion. This mailing may be in letter or post card form. I understand that the information contained in these mailings may be about procedures I have already had performed, about special events or discounts or may be regarding other cosmetic services or products that may be of interest to me. I understand that this permission is good until such time as I revoke it in writing

_____

Signature of Patient

_____ACCEPT _____DECLINE Revision: 7/15/2016