LONE PINE
DERMATOLOGY AND MOHS SURGERY

HIPAA Privacy Consent

I,_____hereby authorize Lone Pine Dermatology to use and disclose my protected health information (PHI) for the following purposes:

- Treatment: My PHI may be used by my healthcare providers to provide me with medical care and treatment.
- Payment: My PHI may be used by my healthcare providers to bill my insurance company or other third-party payers for medical care and treatment I receive.
- Healthcare Operations: My PHI may be used by my health care providers for administrative and other purposes related to the provision of healthcare, such as quality assurance, training, and marketing.

I understand that I have the right to revoke this consent at any time by writing to Lone Pine Dermatology. However, such revocation will not be retroactive.

I have read and understand the Lone Pine Dermatology Notice of Privacy Practices, which explains how my PHI may be used and disclosed.

I have signed this consent form voluntarily and without coercion.

Signature:_____ Date:_____