Dermatology Specialists
Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

You may review our Notice of privacy practices prior to signing this consent. A copy for your review is kept in patient waiting area or you may request a personal copy at the Front Desk.

Use and Disclosure of your Protected Health Information (PHI)

Your Protected Health Information will be used by Dermatology Specialists or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____ _____/____/_____

Name of Patient (print) **Signature of Patient** **Date**

_____ _____/____/_____

Name of Patient Representative / Relationship **Signature of Patient Representative** **Date**

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Please list others we may release your PHI to: _____

Please indicate below whether you agree to allow us to leave a detailed telephone message regarding your test results at any of the phone numbers you have listed.

Agree _____ Deny _____

Office Representive _____ Date _____/_____/_____