

Informed Consent for Uses or Disclosure of Health Information for Treatment, Payment or Health Care Operations

I understand that as part of my health care, Center for Medical Dermatology, PLLC and its affiliates create and maintain health records containing information about my individual health history, symptoms, examination and test results, diagnosis, treatments provided to me, plans for future care or treatment and payment for care provided to me. I understand that this information serves as:

A basis for planning my care and treatment

A means of communication among health professionals who contribute to my care.

A source of information for applying my diagnosis and treatment information to my bill and seeking payment for the services Center for Medical Dermatology, PLLC provides to me.

I understand that Center for Medical Dermatology, PLLC reserves the right to change its Notice of Privacy Practices to reflect changes in the way it handles health records and that I have a right to request a copy of such a new Notice.

I understand I have the right to:

Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, that Center for Medical Dermatology, PLLC is **not** required to agree to the requested restrictions, but that Center for Medical Dermatology, PLLC will be bound to any restrictions it does agree to.

Revoke this consent in writing, except to the extent that Center for Medical Dermatology, PLLC has already taken action in reliance thereon.

Signature Patient/Parent/Legal Guardian

Date

Patient's Name