CLAYTON DERMATOLOGY GROUP

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: This Notice of Privacy Practices and Procedures describes how we may use, obtain, and disclose your protected health information (PHI) to carry out treatment, payment activities, health care operations, and for other purposes permitted or required by law.

Notice of Privacy Practices and Procedures

Treatment – to provide you with health care treatments and services. We may review your health history to form a diagnosis and treatment plan, consult with other doctors, delegate tasks to office staff, call in prescriptions to your pharmacy, or access your prescriptions electronically, disclose needed information to your family or others.

Payment – to bill or collect payment from you, an insurance company or a third party.

Operations – to administrate our office. We may contact you by phone, mail, e-mail, or text message for all notices pertaining to your account including, but not limited to, sending healthcare financial information such as billing statements or payment receipts, appointment reminders and confirmations, and requests for feedback through reviews or surveys. We may leave a detailed message on your voicemail or with whomever answers your phone. We may ask you put your name on a sign-in sheet and may call you by name from the waiting room.

If you choose, please list the name and relationship of the person(s) with whom we may share your healthcare or payment information. _____

I have read the "*Notice of Privacy Practice*s" which provides a more complete description of health information uses and disclosures. A copy will be provided to you at any time upon your request. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to revoke this consent at any time, by giving us written notice, signed by you.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____

Patient Name *Date*

_____ _____

Patient Signature *Mobile phone/ Email*

If other than patient is signing, are you the parent, legal guardian, legal custodian or have a Healthcare Power of Attorney for the patient? Yes _____ No_____

_____ _____

Name of person signing (if other than the patient) *Relationship*

_____ _____

Representative Signature *Date*