CENTRAL
DERMATOLOGY
CENTER

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Central Dermatology Center, P.A. in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Central Dermatology Center, P.A.'s Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such Notice prior to signing this consent form.

Central Dermatology Center, P.A. reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Central Dermatology Center, P.A. does changes the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requesting the Notice from the Front Office Staff of Central Dermatology Center, P.A.

I retain the right to request that Central Dermatology Center, P.A. further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Central Dermatology Center, P.A. is not required to agree to such requested restrictions; however, if Central Dermatology Center, P.A. does agree to my requested restriction(s), such restriction(s) are then binding on Central Dermatology Center, P.A.

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Central Dermatology Center, P.A. in writing. The revocation shall be effective *except* to the extent that the Central Dermatology Center, P.A. has already taken action in reliance on the Consent. *Central Dermatology Center, P.A. may refuse to treat you if you do not sign this Consent Form* (except to the extent that Central Dermatology Center, P.A. is required by law to treat individuals). If you (or authorized representative) sign this Consent Form and then revoke consent, then Central Dermatology Center, P.A. has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONCENTER TO THE ABOVE STATED TERMS.

Date _____ Time _____AM/PM _____/_____
Signature of Patient Date of Birth

_____
Please Print Name

_____
Person Signing on Behalf of Patient/ Relationship

_____
Please Print Name

Phone Consent: I authorize the physicians and staff of Central Dermatology Center, P.A. to:
(Please circle to indicate your preference, and list the preferred phone number)

- Leave a message on my answering machine on Home/Cell Phone? **NO YES Tel #**_____
- Leave a message at my place of employment? **NO YES Tel #** _____
- Discuss my medical condition with a member of my household **NO YES Tel #** _____
  - **If yes, whom** _____ **Relationship** _____

Signature _____**Date** _____
(If the patient is under 18, a parent or guardian must sign. If the patient is over 18, the patient must sign for themselves.)

CONSENT FOR MINOR TO PRESENT FOR TREATMENT

I, _____, give my consent for my son/daughter _____ to bring himself/herself to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's Signature _____ **Date** _____

Witness _____ **Date** _____