Abington Dermatology

PATIENT CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Abington Dermatology originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care or treatment. 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 surgical information to my bill,
- A means by which a third-party payer can verify that services billed were provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can request a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to my signing this consent,
- The right to object to the use of my health information for directory, and
- The right to request restrictions as to how my health information may be used for disclosure to carry out treatment, payment, or health care operations.

I understand that Abington Dermatology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Abington Dermatology reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should Abington Dermatology change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use or disclosure of my health information and/or I WISH TO ALLOW DISCLOSURE OF MY HEALTHCARE INFORMATION TO THE FOLLOWING PERSON(S):

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted used, including disclosures via fax.

I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT and I ACKNOWLEDGE THAT I CAN ASK FOR A COPY OF OUR PRIVACY PRACTICES.

Patient Signature:_____**,Guardian Signature:**_____**Date:**_____