DERMATOLOGY-CHICAGO SC HIPPA CONSENT FORM

This consent is to be used for treatment, payment or other healthcare options.

I, _____, understand that as part of my health care, the doctors of Dermatology-Chicago SC., originate and maintain records describing my health history, symptoms described, examinations preformed, test results, diagnoses, treatments, and plans for future care or treatment. I understand that this information serves as: (1) a basis for planning my care and treatment. (2) A means of communication among health professionals who contribute to my care. (3) A source of information for applying my diagnosis and surgical information to my bill. (4) A means by which a third party payer can verify that services billed were actually provided, and (5) A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have can receive a Notice of Information that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dermatology-Chicago SC has the right to change the policies of the office and will notify the patient if this is necessary. I understand that I have the right to request restorations as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. However, I also understand that Dermatology-Chicago SC may not be required to agree to the restrictions requested.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand and accept the terms of this consent.

Signature_____ Date: _____

Permission to contact patient.

I give the office of Dermatology-Chicago SC permission to call me at home work or on my cell. Messages may be left on answering machines/voice mail or sent to me in the mail. I also agree to use email if the doctor thinks it is appropriate.

Signature_____ Date: _____

Dermatology-Chicago SC may discuss my health information with the following family member/representative. Name of individual(s).

_____

Signature _____ __ Date:_____