GULF COAST DERMATOLOGY
PATIENT CONSENT FOR USE, DISCLOSURE OR REQUEST OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

Patient Name:_____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for services information. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

"ONLY AS PERMITTED BY STATE OR FEDERAL LAW", you are giving this practice CONSENT to do the following:

- **To disclose, as may be necessary, your protected health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**

- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.**

- **To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to insurance company/s, other agencies and/or individual(s) for payment of our services.**

- **To leave appointment reminders or information we believe necessary for your treatment or payment on your answering machine or with a member of your household. The information will be the minimum necessary in our professional judgment.**

- **To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.**

- **If you choose, please list by name and relationship of persons with whom we may share your healthcare or payment information_____**

- You may request a copy of, or as a new patient, will be given a copy of our **"*Notice of Patient Privacy Practices"*** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have read or have had the right to read the **"*Patient Health Information Privacy Practices"*** prior to signing this consent.

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

_____ _____ _____

Signature | Print name of person signing | Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP_____. If you are not the parent, please provide a copy of your legal authority for this patient.

FOR OFFICE USE ONLY

Patient refused to sign the consent form. Reason:_____ Date:_____