CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information (PHI) by The Dermatology Center, PSC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of the Dermatology Center, PSC, I understand that diagnosis and treatment of me by The Dermatology Center, PSC may be conducted upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Dermatology Center, PSC is not required to agree to the restrictions that I may request. However, if The Dermatology Center, PSC agrees to a restriction that I request the restriction is binding on The Dermatology Center, PSC.

I have the right to revoke this consent, in writing, at any time, except to the extent that The Dermatology Center, PSC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare re provider, a health plan, my employer or a health care clearinghouse, this protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review The Dermatology Center, PSC's Notice of Privacy Practices prior to signing this document. The Dermatology Center, PSC's Notice of Privacy Practices has been provided to me upon my request. The Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations of The Dermatology Center, PSC. The Notice of Privacy Practices or The Dermatology Center, PSC is also provided in the office of the Privacy Officer for The Dermatology Center, PSC. This Notice of Privacy Practices also describes my rights and The Dermatology Center, PSC's duties with respect to my PHI.

The Dermatology Center, PSC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by forwarding a written request to Privacy Officer c/o the Dermatology Center, PSC, 825 University Woods Drive, Suite #8, New Albany, IN 47150 or asking for one at the time of my next appointment.

** Please list the person(s) that The Dermatology Center, PSC may release your PHI to:

Name _____ Relation _____ Phone # _____

Name _____ Relation _____ Phone # _____

Name _____ Relation _____ Phone # _____

Do we have your (patient) permission to leave a message on your answering machine regarding test results, prescriptions or any other information pertinent to your medical care? Yes_____ No _____

Signature of Patient or Parent/ Personal Representative _____

Printed name of Patient or Parent/Personal Representative _____

Relation to Patient: (Self) (Parent Personal) (Representative) Date_____