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

Patient Name: _____ DOB: _____Account: _____

I understand that as part of my health care, Bellaire Dermatology Associates (BDA), creates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A tool to notify me of various events, clinical studies, and ongoing opportunities for medical care related to my medical history
- A basis for planning my care & treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis, medical and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and the competence of healthcare professionals.

I hereby consent to the clinic's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the clinic's ***Notice of Privacy Practices***, which describes the obligations of the clinic regarding its use and disclosure of my individually identifiable health information and my rights regarding this information.

Bellaire Dermatology Associates is authorized by this form to disclose and/or discuss my protected health information with the following named people (identified by relationship, date of birth, and phone number):

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____ DOB: _____ Phone: _____
Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

I understand that I have the right to revoke anyone listed above on this authorization by completing a new copy of this form. All revocations must be sent to the clinic address to the attention of the ***Privacy Officer, Bellaire Dermatology Associates, 6565 West Loop South, Suite 800, Bellaire, Texas, 77401,*** and are not effective until received by such.

By checking one of the boxes below, I authorize Bellaire Dermatology Associates to leave a voice mail message concerning biopsies, tests or lab results in the event they are unable to contact me directly via telephone.

☐ MAY leave voice mail message ☐ MAY NOT leave voice mail message

By checking one of the boxes below, I authorize Bellaire Dermatology Associates to communicate with me via unsecured email or the patient portal concerning biopsies, tests or lab results in the event they are unable to contact me directly via telephone.

☐ MAY send unsecured email messages ☐ MAY NOT send unsecured email messages

_____ _____
Signature ***Date***

_____ _____
Responsible Party & Relationship to Patient ***Date***

Reset Checked Boxes