San Antonio Skin and Cancer Clinic

DIPLOMATS OF THE AMERICAN BOARD OF DERMATOLOGY
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TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my health care, San Antonio Skin and Cancer Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any 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 the many health professionals who contribute to my care,
3. A source by which a third party payer can verify that services billed were actually provided, and
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have seen posted the Notice of Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

1. The right to review the notice prior to signing this consent.
2. The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

I understand that San Antonio Skin and Cancer Clinic 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 also 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 San Antonio Skin and Cancer Clinic reserves the right to change their notice and practices prior to implementation, in accordance with Section164.520 of the Code of Federal Regulations.

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 uses, including disclosures via fax.

I further understand that as part of this organizations treatment, payment or health care operations, it may become necessary to request protected health information from another entity and I consent to such disclosure for these permitted uses, including via fax.

I wish to have my Private Health Care Information given to: _____

Relationship to patient _____

I fully understand and accept the terms of this consent.

Printed name: _____

Patient's Signature _____ Date: _____