



# Visage Dermatology

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that as part of my health care, the practice originates 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 basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care, such as referrals.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually rendered.
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

We can provide you with a “Notice of Patient Privacy Practices” that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions:

**I request the following restrictions to the use or disclosure of my health information:**

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**Please tell us with whom we may discuss your protected health information:**

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(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s)))

### Messages or Appointment Reminders:

May we leave a message at your **home** using doctor’s/practice name: Yes ( ) No ( )

May we leave a message at your **work** using the doctor’s/practice name Yes ( ) No ( )

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept / decline** (please circle one) the information of this consent.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Person Signing