DASC
DERMATOLOGY &
ADVANCED SKIN CARE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Patient DOB: _____/_____/_____ **Today's Date: _____/_____/_____**

I hereby authorize the use and disclosure of my protected health information (PHI) as described below:

CONTACT INFORMATION:

Please indicate how we may contact you and if we can leave a detailed message:

Contact Method	Contact Details (phone number, etc.)	Check this box if we **CAN** leave a ***detailed*** message
Home Phone		
Cell Phone		
Email Address		
Patient Portal		

I authorize Dermatology & Advanced Skin Care to leave a detailed message regarding the following information:

____ Appointment Information ____ Information about cosmetic appointments

____ Medical Information/Records ____ Financial Information ____ Test/Pathology Results

This information may be disclosed to (eg. spouse, family member, other provider, etc.):

_____

_____

_____

Name and Relationship; Phone/Address if applicable (eg. Provider's office)

1. Dermatology & Advanced Skin Care may use and disclose my PHI to carry out treatment, payment and healthcare options (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization. The practice, however, reserves the right to decline treatment to me based upon my refusal.
3. I understand that I have a right to receive a copy of this authorization, if requested by me.
4. I understand that I may revoke this authorization at any time except to the extent that the practice has already made disclosures in reliance upon my prior consent.

5. This authorization expires on the following date or event (if left blank, this form will not expire)*:

*If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.

_____ _____ _____/_____/_____

Signature of Patient or Guardian Name of Patient or Guardian Date