ESSEX DERMATOLOGY

Patient Authorizations

First Name	Last Name	Nickname	Date of Birth

Emergency Contact Name	Relation	Phone Number

Consent to Treatment / Assignment of Benefits / Uses and Disclosures of Protected Health Information

1. I consent to any and all health care treatment and diagnostic procedures provided by Essex Dermatology, LLC and its associated physicians and personnel.

2. I consent for the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Essex Dermatology, LLC Notice of Privacy Practices.

3. I authorize payment of medical benefits to Essex Dermatology, LLC or their designee for services rendered.

4. A copy of the Notice of Privacy Practices will be provided to me in the office for review at my request, and is also available at essexderm.com at any time I wish to access it.

→ **Signature of Patient / Guardian / Representative: _____ Date: _____**

HIPAA Disclosure Notice & Authorizations

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. *Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

I wish to be contacted in the following manner (check all that apply)

□ **Home phone** □**Cell phone** □**Other phone** _____
□Ok to leave detailed message
□ Leave message with call back number only

Written communication
□Ok to mail my home address

Please indicate anyone other than yourself that is authorized to receive information about your care

Name: _____ **Relation:** _____ **Phone #:**_____

Information to be released: Medical _____ Financial _____

- I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I understand the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer protected by federal or state law.
- I understand I have the right to refuse this authorization and that my treatment will not be conditioned on signing.

*****This authorization will remain in effect until revoked by the patient.*****

→ **Signature of Patient / Guardian / Representative: _____ Date: _____**