

Health Information Consent

I understand that Dermassociates, LTD uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use and disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Dermassociates, LTD's Notice of Information Practices for more information about how my protected health information may be used and disclosed. I understand that Dermassociates, LTD may change its information practices, but before doing so, a new Notice will be posted in the waiting area and each examination room. I may also call (618)-397-6605 at any time to request a copy of the Notice.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information. Dermassociates, LTD is not required to agree to such restrictions, but if Dermassociates, LTD does agree, it must abide by those restrictions. I understand that I have the right to revoke this consent, in writing, except where Dermassociates, LTD has already made disclosures in reliance on my prior consent.

Name of Patient: _____

Signature of Patient or Legal
Representative _____

If signed by someone other than the patient:

Print Name: _____ Date: _____

Relation to Patient: _____