Armstrong Dermatology and Skin Cancer Center P.A.
9170 Oakhurst Road, Suite One
Seminole, FL 33776
(727) 717-DERM (3376)

Patient Consent to the Use, Disclosure and Request of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of the Opportunity to Read and/or Receive the Health Information Privacy Practices

Patient Name:_____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and only as permitted by state or federal law, you are giving this practice your consent to do the following:

- **To disclose, as may be necessary, your health information to other healthcare providers (such as, referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare**
- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment**
- **To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of our services**

We are providing you with the opportunity to read the "*Notice of Patient Health Information Privacy Practices"* that provides a more complete description of health information uses and disclosures. You have the following rights:

- The right to read the ***"Patient Health Information Privacy Practices"*** prior to signing this consent
- The right to request a copy of the ***"Patient Health Information Privacy Practices"*** for your own personal use

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____	_____	_____
Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ] RELATIONSHIP_____

*Are there persons (i.e. family members) to whom we may disclose your healthcare or payment information?
Please list_____

FOR OFFICE USE ONLY

[ ] "Consent form" reviewed by (employee)_____ on (date) _____
[ ] Patient refused to sign the consent form. Reason for patient refusal to sign_____
[ ] Restrictions added by the patient (see restrictions listed above)