**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)