VAN DAM DERMATOLOGY & LASER CENTER | VERSA MEDI•SPA

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that Van Dam Dermatology & Laser Center has the "**Notice of Privacy**" and the "**Red Flag Rule**" policies in the office waiting room for me to review.

Compliance with the "Red Flag Rule" is required by the federal government and is intended to help safeguard against identity theft. The "Red Flag Rule" requires that we obtain a photo ID that confirms you are the person you say you are.

I consent to the use or disclosure of my Protected Health Information (PHI) by Van Dam Dermatology & Laser Center for purposes of Treatment, Payment and Health Care Operations as described in the "Notice of Privacy".

I understand that this consent remains in effect until I revoke it. I have the right to rescind this consent in writing at any time, but such revocation will not apply to any uses or disclosures that occurred before the effective date of the revocation.

I understand that Van Dam Dermatology & Laser Center will attempt to communicate with me regarding my PHI and that I have the right, at any time, to request restrictions and changes in how my PHI is used or disclosed and how I am contacted by Van Dam Dermatology & Laser Center.

I understand that I have a right to a copy of this consent form.

The **Notice of Privacy Practices** for Van Dam Dermatology & Laser Center is subject to change and revision. If we make any revisions, paper copies of that revision will be available in our office as of the effective date and will also be posted in our waiting room.

I hereby acknowledge all of the above:

☐ Patient Refused to Sign

_____
Print Patient Name Date

X_____ _____
Signature of Patient or Personal Representative Relationship of Personal Representative to Patient

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize Van Dam Dermatology to disclose
(Print your name)

☐ **YES**, Release all of my entire Protected Health Information.

To: _____
(Print **NAME** and **RELATIONSHIP** of person we may speak to regarding your Protected Health Information)

☐ **ONLY**, My Protected Health Information consisting of: _____
(Describe the Protected Health Information to be disclosed)

To: _____
(Print **NAME** and **RELATIONSHIP** of person we may speak to regarding your Protected Health Information)

☐ **NO**, I want my Protected Health Information to be discussed with me only.

I understand the purpose for disclosing this Protected Health Information to the person noted above. I understand that these changes/ restrictions will remain in effect until I rescind them in writing.

Signature: X_____ Date: _____

VAN DAM DERMATOLOGY & LASER CENTER | VERSA MEDI•SPA

Information on the Privacy Form

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS
states that we are HIPAA compliant.
We follow all privacy rules to keep your information private.

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION
lets us know whom we can legally speak with besides the patient.

This would include family members, friends, assistants, etc.
Add the name(s) & relationship in the YES or ONLY line.
If you are the only person that we would discuss
your care with check the NO box.

Some examples of the second part of the form that you would check YES or ONLY:

- **A spouse calling with questions on a prescription or appointment**
- **A patient over the age of 18 whose parents are still involved in their medical care**
- **The adult child of an elderly parent that is involved in their medical care**
- **Minor patients (under 18) who has a caregiver besides the parent(s) (i.e. grandparent, nanny)**