ADVANCED DERMATOLOGIC SURGERY, P.A.
ADS AMBULATORY SURGERY CENTER

Consent to the Use and Disclosure of Health Information for Treatment, Payment and Healthcare Operations

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

* I authorize Advanced Dermatologic Surgery, P.A. and ADS Ambulatory Surgery Center to disclose my health information to specified individual(s), other than my health care providers, for up to 6 months from my treatment date. **(Name Individual(s)** _____
Spouse, Children, Siblings, Parents or Friends

_____

* I authorize Advanced Dermatologic Surgery, P.A. and ADS Ambulatory Surgery Center to leave detailed messages regarding my health information or test result on my telephone voicemail. ____ **Y** ____ **N**

I understand that if the person(s) that receives the information is/are not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Advanced Dermatologic Surgery, P.A. and ADS Ambulatory Surgery Center, its employees, and physician(s) from all liability arising from this disclosure of my health information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Printed Patient's Name **Date of Birth**

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

* _____ _____
Signature of Patient or Legal Representative **Date** Signature of Witness Date