COLORADO DERMATOLOGY SPECIALISTS

PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)

With my consent, Colorado Dermatology Specialists may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Colorado Dermatology Specialist's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Colorado Dermatology Specialists reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Colorado Dermatology Specialist's Privacy Office at 7000 E Belleview Ave, Suite 209, Greenwood Village, CO 80111.

With my consent, Colorado Dermatology Specialists may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

Phone number where a detailed message can be left: _____

I authorize the following people to be approved as delegates, to give and/or receive medical information on my behalf:

_____ _____
Name and relationship to patient Phone number

_____ _____
Name and relationship to patient Phone number

With my consent, Colorado Dermatology Specialists may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Colorado Dermatology Specialists restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If it does, it is bound by this agreement.

By signing this form, I am consenting to Colorado Dermatology Specialist's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Colorado Dermatology Specialists may decline to provide treatment to me.

Colorado Dermatology Specialists provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Patient/Guardian Print Name Patient/Guardian Signature

_____ _____
Please print name of accompanying adult Today's Date