MR#:_____

DermOne™
Dermatology, Cosmetic
& Scarless Vein Center

NOTICE OF PRIVACY PRACTICE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION, CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION & REFUSAL TO AUTHORIZE OR CONSENT

I, _____, DOB:_____, AUTHORIZE **DR. KAMRAN GOUDARZI** AND/OR **DR. MICHAEL CAHN** TO DISCLOSE THE FOLLOWING INFORMATION FROM MY RECORDS FOR THE PURPOSE OF TREATMENT, HEALTH CARE OPERATIONS, BILLING AND PAYMENT, OR OTHER:_____

INFORMATION TO BE DISCLOSED:

- ☐ Health record (includes: treatment, health care operations, billing and payment, etc.)
- ☐ History & physical examinations
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Operative notes
- ☐ Ultrasound reports
- ☐ X-ray reports
- ☐ Laboratory tests
- ☐ Photographs, video tapes, digital or other images
- ☐ Discharge summaries
- ☐ Billing information
- ☐ Other:_____
- ☐ **ALL OF THE ABOVE**

INFORMATION IS TO BE DISCLOSED TO:

- ☐ Family, Guardian or Representatives (please specify):_____
- ☐ Physicians
- ☐ Clinics, hospitals or surgical centers
- ☐ Insurance companies
- ☐ Other:_____
- ☐ **ALL OF THE ABOVE**

The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of this information to the extent indicated and authorization herein.

I have read the contents of the NOTICE OF PRIVACY PRACTICES. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment and health care operations.

SIGN:_____ _____

PATIENT/LEGAL GUARDIAN | RELATIONSHIP TO PATIENT

_____ _____

WITNESS | DATE

NOTICE TO PATIENT: By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of treatment, various activities associated with payment and healthcare operations. Our NOTICE OF PRIVACY PRACTICES provides more detail on our treatment, payment activities and health care operations. If there is not a copy of the NOTICE accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care. This authorization will expire only when you notify us in writing or in person.

REFUSAL TO CONSENT: NOT TO AUTHORIZE/CONSENT TO RELEASE RECORDS TO ANYONE.

By signing below, you agree that it has been explained and you understand that no records will be sent to anyone without you returning to the office to complete a new release form.

I, _____ (Chart #:_____), **DO NOT WANT MY RECORDS SENT TO ANYONE**.

SIGN:_____ _____

PATIENT | DATE