STILLWATER DERMATOLOGY CLINIC
DR THOMAS HALL

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Stillwater Dermatology Clinic for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Stillwater Dermatology Clinic. I understand that analysis, diagnosis or treatment of me by Stillwater Dermatology Clinic may be conditioned upon my consent as evidence by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Stillwater Dermatology Clinic is not required to agree to all restrictions that I may request. However, if Stillwater Dermatology Clinic agrees to a restriction that I request, the restriction is binding on Stillwater Dermatology Clinic. I have the right to revoke this consent, in writing, at any time, except to the extent that Stillwater Dermatology Clinic has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my prescription history from external sources, my demographic information (name, address, date of birth), collected from me and created or received by my physician, another health care provider, a health plan, or my employer. This protected health information relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me.

By Oklahoma State Law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome. (AIDS).

By law we are required to provide you with the information of our Notice of Privacy Practices as to how your medical information may be used and disclosed by us. Our full length notice of Privacy Practices is available at the reception desk for your review. As a patient you have the following rights:

1) The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close friends or any other person identified by you. We are, however not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
2) The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
3) The right to inspect and copy your PHI.
4) The right to amend your PHI.
5) The right to receive an accounting of disclosures of your PHI.
6) The right to a paper copy of this notice upon request.
7) The right to notification in the event of a breach of your protected PHI.
8) The right to request that a medical record not be disclosed to your insurer if you pay for the service out of pocket.

We cannot disclose your protected health information to anyone without your written permission.
PLEASE LIST ANYONE THAT WE HAVE YOUR PERMISSION TO SPEAK TO ABOUT YOUR PROTECTED HEALTH INFORMATION:

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I request the following restrictions to the use and/or disclosure of my health information:

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(Please check one) *You may____ / may not____ leave appointment reminders and/or medical information with my message service, voicemail, or on my answering machine.*

____ ____________________

Patient Signature **Date**