DERMATOLOGY INSTITUTE
& LASER CENTER

HIPAA Patient Consent Form

This consent form describes how Dermatology Institute and Laser Center will use and disclose protected health information about you to carry out treatment, payment and healthcare options. You have the right to review the Notice of Privacy Practices prior to signing this consent form. Dermatology Institute & Laser Center reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained on our website, www.drros.com, or by requesting a copy from our office at Dermatology Institute & Laser Center at 1100 Clifton Avenue, Suite F, Clifton, NJ 07013.

When contacting you for appointment reminders, insurance items or any calls regarding your care, may we leave a message or state who is calling on your :

Home Phone: ❍ Yes ❍ No Work Phone: ❍ Yes ❍ No

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient, or your guardian.

Please list below whom we may discuss your situation:

Name: _____ Name: _____

Relationship:_____ Relationship:_____

Phone: _____ Phone: _____

By signing this form, I am consenting to the Dermatology Institute & Laser Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature Date Printed Name

_____

Relationship to Patient (if other than patient)

_____ _____

Witness - Signature (Practice Representative) Date Printed Name (Practice Representative)