Authorization for use or disclosure of protected Health Information (HIPPA)

Name:_____Date of Birth:_____

_____ I understand that I have the right to review and/or retain a copy of the Notice of Privacy Practices prior to signing this consent.

_____I agree that First Capitol Dermatology may discuss, fax, leave a voicemail, or mail information pertaining to my treatment, to myself, authorized persons, my PCP and referring physician.

Please list anyone you would like us to be able to release or discuss information with regarding your care

Name:_____Phone#_____Relationship:_____

Name:_____Phone#_____Relationship:_____

Name:_____Phone#_____Relationship:_____

I authorize FCD to request medical information including pathology slides, test results, photos, prescriptions and any other records necessary for my treatment.

Permission to Bill Insurance and Notice of Office Policies

_____I authorize First Capitol Dermatology to release to Medicare or my insurance carrier any information needed to process my insurance claims. I permit this authorization to be used to request payment of insurance benefits to First Capitol Dermatology.

_____I have been informed of the following office policies:

1. I understand that I must present a valid photo ID and a current insurance card at the time of treatment and that all copays are due at the time of service.
2. I am aware that once my insurance has processed its portion of the office charges, I will receive a statement with the remaining balance. I understand that payment for the charges is due when the statement is received and I may contact the office to inquire about payment plans if needed.
3. I am aware that photographs will be taken in the office throughout my care here to document and aid in my treatment. These photos may also be used for medical education, lectures and publication in a medical journal. No identifiable photograph of me will be published without my consent.
4. A secure username and password for access to my medical information online through our patient portal will be provided to me.
5. Medical records might be used at Grand Rounds at Saint Louis University by providers for opinions and/or treatments.
6. I understand that if I initiate electronic communication with my provider, my provider may respond by the same method as the original electronic communication. The office cannot guarantee security of electronic communication initiated by a patient.
7. I understand that I may refuse to sign this authorization or may revoke authorization at any time in writing

Signature of Patient/Legal Representative:_____ Date:_____