

# Fair Oaks Skin Care Center, Ltd.

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## PATIENT ACKNOWLEDGEMENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND OFFICE POLICIES

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

With my consent, Fair Oaks Skin Care Center, Ltd, and their employees (“The Practice”) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

(Please refer to The Practice’s Notice of Privacy Practices for a more complete description of such disclosures.) I also understand I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, the Practice may call my home or other designated location to leave messages on voice mail or in person in reference to any items that assists the Practice in carrying out appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, etc.

**Phone number to call:** \_\_\_\_\_

With my consent, the Practice may mail to my home or other designated locations(s) any items that assist the practice in appointment reminders and patient statements.

The following individually identifiable health information – test results, social, mental and physical health, appointment information, billing and/or billing related account information, complete history and physical information and demographic information may be disclosed to the parties listed below.

By signing this form, I am consenting to Fair Oaks Skin Care Center, Ltd. and its employees’ use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations.

Name of Person authorized to receive and/or disclose certain protected health information about me to or for the party or parties listed below.

**Name of Person:** \_\_\_\_\_ **Relationship to me:** \_\_\_\_\_ **Specify Disclosure:** \_\_\_\_\_

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY:** \_\_\_\_\_

**DATE:** \_\_\_\_\_