PBC Dermatology

3400 Forest Hill Boulevard
West Palm Beach, Florida 33406

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVES

Name:	DOB:	Today's Date:

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS:

I consent to PBC Dermatology using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that PBC Dermatology reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying PBC Dermatology in writing, except to the extent that PBC Dermatology has taken action in reliance on my consent.

I, _____ , give my written consent for PBC Dermatology to share information regarding my protected health information and care to the following listed persons. I understand that these persons may be treated as personal representatives of myself.

Do not discuss my information with anyone other than myself at any time. ❍
*(Must complete "Request for Confidential Communication of Protected Health Information" form.)

Personal Representatives that you may share my health information with:

_____
(Name) (Relationship) (Phone)

_____
(Name) (Relationship) (Phone)

_____
(Name) (Relationship) (Phone)

You may leave a message: (please check all that apply)

At Home ❍ At Work ❍ On answering machine ❍ Written communications (mail/email) ❍

X _____
Patient's Signature Witness' Signature

_____
Date Date