HEYMANN, MANDERS, GREEN & SOMMER, LLC.

CONSENT, DISCLOSURE, AND AUTHORIZATION FORM

Patient Name:____________________________________ **SSN#** : ____________________

Address:____ **DOB**: ____________________

Email Address:____________________________________ **MR# (office use only):**________

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Heymann, Manders, Green & Sommer, LLC. ("HMGS") and all physicians, nurses, and other ancillary medical personnel of HMGS, to perform medical examinations and provide routine dermatologic care for all my visits to HMGS. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment, and healthcare operations of HMGS, as further described below. Any photographs or other images taken will become part of my medical record. HMGS will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that HMGS will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the HMGS HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that HMGS has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, HMGS will post a new notice in the office. I may contact HMGS at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I also may access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize HMGS to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of HMGS. I understand that, for example, my health information may be used or disclosed by HMGS to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by HMGS; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand HMGS may release my protected health information as required by law or court order.

Patient Name:___________________
Date of Birth:____________________

Disclosures to Authorized Individuals

I understand that HMGS may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name:__________________________________ Relationship: ____________________________

Address:________________________________ Phone: ________________________________

Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name:__________________________________ Relationship: ____________________________

Address:________________________________ Phone: ________________________________

Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Emergency Contact

In case of an emergency, please contact the below individual. You may provide general information about me, including as necessary to communicate information about the emergency. If this person is also listed above, you may provide information as authorized above.

Name:__________________________________ Relationship: ____________________________

Address:________________________________ Phone: ________________________________

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone (h) ________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Work Telephone (w) ________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell Telephone (c) _________________ ☐ Detailed Message ☐ Call Back Message Only

☐ Mail to Home Address ☐ Mail to Work Address

Mailing address: ____

I understand that if I have checked the box "detailed message," I agree that HMGS may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

Patient Name:___________________
Date of Birth:____________________

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document:

Patient Name____Date ___________________________

Patient Signature ____

Authorized Individual (Parent/Guardian) Name ____

Authorized Individual Signature ____

Basis of Authority (e.g., parent, guardian): ____

(Authorized individuals will be required to provide proof of authority)