San Luis Dermatology & Laser Clinic, Inc.
15 Santa Rosa Street – San Luis Obispo, CA 93405
1551 Bishop Street, Suite 410, San Luis Obispo, CA 93401

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

In 1996, Congress passed the Health Portability and Accountability Act (HIPAA). Part of this provides for confidentiality of a patient's health information.

I understand that as part of my health care, the physicians and staff of San Luis Dermatology & Laser Clinic, Inc. maintain paper and electronic records describing my health history, symptoms, examination and test results, diagnose, treatment and any plans for future are or treatment. I understand that San Luis Dermatology & Laser Clinic, Inc. and all staff members are required by HIPAA to keep my personal and health care information secure and confidential and that practices are in place to meet these requirements. I understand that my personal and health information services as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for billing purposes, both to insurance plans and directly to the patient

I understand that I have the right to request restrictions on the use of my health care information. I also understand that by refusing to sign this consent regarding my health information, San Luis Dermatology & Laser Clinic, Inc. may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I give San Luis Dermatology & Laser Clinic, Inc. permission to use my information, both personal and health-related, for the following purposes:
Sharing of personal and medical information, with other health care or health care related professionals, (such as outside Lab or Pathology) as determined by the physicians and staff of San Luis Dermatology & Laser Clinic, Inc. to be in my best interest for proper medical treatment. ***Please note: you will be billed for any lab; cultures and pathology separately from an outside laboratory.***

- Sharing my personal and medical information with Medicare and private insurance plans for billing purposes and for review of any contested charges/payments.

- To leave telephone/voice mail messages, to fax, mail and/or electronic mail to remind me of my appointments or to respond to your questions.

- I have received or have been allowed to view a copy (posted in waiting area, and @ www.sanluisdermatology.com) of SLDLC's office privacy notice as required by HIPAA.

- **I hereby give authorization to verbally or otherwise share my personal or medical information with a family member or any individual which I have designated below:**

  _____ Relationship _____
  Name Parent/Spouse/Child/Friend/Other

  _____ Relationship _____
  Name Parent/Spouse/Child/Friend/Other

_____ _____
Patient Signature (Parent signature, if a minor) Date

_____ _____
Witness Date