Venice Avenue Dermatology - PHI Consent

Patient Consent for Release of Personal Protected Health Information

I hereby give consent for **Venice Avenue Dermatology** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). **Venice Avenue Dermatology's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.

WITH THIS CONSENT, Venice Avenue Dermatology, MAY DISCUSS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS WITH THE FOLLOWING PERSON(S):

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBERS, AND RELATION TO YOU

Name:_____ **Phone**_____ **Relation:** _____

Name:_____ **Phone**_____ **Relation:** _____

Name:_____ **Phone**_____ **Relation:** _____

Name:_____ **Phone**_____ **Relation:** _____

Name:_____ **Phone**_____ **Relation:** _____

☐ **NO ONE OTHER THAN MYSELF IS PERMITTED TO HAVE MY INFORMATION**

I understand that **Venice Avenue Dermatology** cannot share my health information with a family member, including my spouse, child, caregiver or other person unless they are listed above. I also understand that this release of information will remain in effect unless I revoke my consent in writing, except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Venice Avenue Dermatology** may decline to provide treatment to me.

By signing this form, I am consenting to **Venice Avenue Dermatology's** use and disclosure of my PHI to carry out TPO.

_____	_____	_____
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian	Date