PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Hubbell Dermatology & Aesthetics, APMC may use and disclose protected health information (PHI) about me to carry out and exchange information necessary for treatment, payment or operations of health care business (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Hubbell Dermatology & Aesthetics, APMC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Hubbell Dermatology & Aesthetics, APMC may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, including, but not limited to, appointment reminder cards and patient statements.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hubbell Dermatology & Aesthetics, APMC 's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hubbell Dermatology & Aesthetics, APMC may decline to provide treatment to me.

By signing this form, I hereby acknowledge receipt of Hubbell Dermatology & Aesthetics, APMC Notice of Privacy Practices with respect to the patient. At any time, I have the right to review the Notice of Privacy Practices that may be obtained by forwarding a written request to Hubbell Dermatology & Aesthetics, APMC Privacy Officer at 913 South College Suite 216, Lafayette, LA 70503 or you may view them on our website at www.skinexpert.com.

Please list whom you give our office permission to discuss your medical and financial information with. Please write "None" if you do not give us permission to speak with anyone.

	Name:	**Relationship:**
1)	______________________________	____________________
2)	______________________________	____________________

______________________________ ____________________

Signature of Patient or Legal Guardian Date

____

Patient's Printed Name

913 S. COLLEGE ROAD, STE 216
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