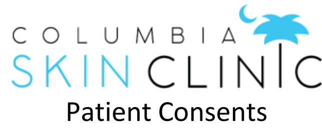
Date: ____________________



Patient Consents

1. **Communication Consent**

Messages from Columbia Skin Clinic may be left for me at the following locations:

□ Home □ Cell/Text □ Work

List anyone with whom we may discuss your person, medical, or financial information, i.e. family members or friends. The identity of these designated parties will be verified prior to the release of any information.

Name: ______________________________ Relationship: ________________ Phone: __(____)______________
Name: ______________________________ Relationship: ________________ Phone: __(____)______________
Name: ______________________________ Relationship: ________________ Phone: __(____)______________

2. **Emergency Contact**

Name: ______________________________ Relationship: ________________ Phone: __(____)______________

3. **Consent to treat a minor** (if 18 years of age of younger)

I (We) the undersigned parent(s) or legal guardian of ________________________________, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his/her best judgment may deem advisable. A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment. This consent shall remain effective until one year from the date of this form.

Parent/Guardian Signature ____

4. **Patient Consent for Medical Photography**

I give my consent for medical photographs to be made of me (or for the person for whom I am the legal guardian). I understand that these images will be stored in the private, secure medical record with controlled access mandated by the Privacy Rule.

Name of Patient: ______________________________________
Name of Guardian: ____________________________________ Signature: _____________________________
(If patient is 18 years of age or younger)

5. **Patient Information Consent**

I have read and understand Columbia Skin Clinic's Notice of Information Practices. I understand that Columbia Skin Clinic will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment/payment. I understand that I have the right to restrict how my PHI is used if I notify the practice of my wishes. I understand that Columbia Skin Clinic will consider requests for restriction on a case-by-case basis, but is not legally bound to comply with requests for restrictions. I understand that Columbia Skin Clinic does not allow the use of PHI for the purposes of marketing, fundraising, solicitation, or research studies. I hereby consent to the use and disclosure of my PHI for the provision of treatment facilitation of payment, evaluation of service quality, or administrative operations.

Patient Name: ________________________________ Signature: ______________________ Date: ___/___/____