Peraza Dermatology Group
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HIPAA Personal Health Information Permissions

I, ______________________________________, consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)** and this consent by Peraza Dermatology Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Peraza Dermatology Group. I understand that diagnosis or treatment of me by Jose E. Peraza, MD and Daniel M. Peraza, MD and/or their assigns may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Peraza Dermatology Group Notice of Privacy Practices prior to signing this consent. Peraza Dermatology Group's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Peraza Dermatology Group duties with respect to my protected health information.

Please also note that as provided in Peraza Dermatology Group's Notice of Privacy Practices, Peraza Dermatology Group reserves the right to change the privacy practices that described in such notice. I may obtain a revised Notice of Privacy Practices by accessing the Peraza Dermatology Group website, by calling the office at 603.542.6455 and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

The following people may have access to my Health Information:

Name	Relationship
1.	
2.	

I ☐DO ☐ DO NOT authorize Peraza Dermatology Group to leave a message either on my answering machine or my voice mail about appointments, billing questions, biopsy/lab reports, prescription information or other information as needed.

By signing this I acknowledge that a copy of Peraza Dermatology Group's Notice of Privacy Policies has been made available to me.

____
Printed Name – Patient or Personal Representative

____ ____________________________________
Signature of Patient or Personal Representative Date