

*Hill Center for Dermatology, PC
17560 S. Golden Road, Suite 100
Golden, CO 80401
303-526-1117*

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT OR
HEALTHCARE OPERATIONS**

NAME: _____

DATE OF BIRTH: _____

I understand that Hill Center for Dermatology, PC originates and maintains health records describing my personal and family health history, symptoms, examinations, test results, diagnosis, treatment and plans for future care.

I UNDERSTAND THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment.
- A means of communication with healthcare professionals who contribute to or participate with my care.
- A source to provide diagnosis and treatment to my insurance company and/or third party payor for billing purposes.
- A means by which my insurance company and/or third party payor can verify services.
- A tool for ensuring quality of care and competency of healthcare professionals.

I UNDERSTAND I HAVE THE RIGHT:

- To restrict how my healthcare information is used or disclosed.

All requests for restrictions must be in writing and given to your provider.

Signature of patient or guardian

Date