SUNFLOWER
DERMATOLOGY & MEDICAL DAY SPA

Patient ID: _____
Provider: _____

Consent to Medical Care

I understand the procedures standard to the care of dermatology and consent to undergo dermatologic care including any necessary procedures. These procedures include, but are not limited to cryosurgery, shave and punch biopsies and cosmetic and medically necessary procedures. I will be informed of potential risks/side effects PRIOR to the procedure.

Consent to Use and Disclose Protected Health Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers, to conduct normal healthcare operations such as quality assessments and physician certifications, and to support day-to-day healthcare operations in the practice.

I have been made aware that there is a copy of Sunflower Dermatology & Medical Day Spa, LLC, Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the office to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Print name of patient	**Signature of patient**	**Date**
Print name of parent/guardian	**Signature of parent/guardian**	**Date**

Reviewed by (provider signature): _____