ALDO LEOPARDI

CONSENT FORM

Consent for Use and Disclosure of Personal Health Information and Patient Imaging

This form authorizes Dr. Aldo Leopardi and staff to use and disclose your protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies (NPP) to gain a clear understanding of how we may use and disclose your NPP.

Please initial each paragraph:

___ I have read your Notice Privacy Polices and I consent to your use of my PHI for the purpose of healthcare operations, treatment and payment.

___ I hereby authorize Dr. Aldo Leopardi and staff to take clinical photographs, videos or digital images of my condition, both before and after treatment. These images may be presented to scientific, medical and similar groups, and/or printed in journals and publications for teaching of education purposes. In certain cases, other prospective patients may view them. Although the images will not be labeled with my name, I am aware that certain images may reveal my identity. All images remain the property of Dr. Aldo Leopardi and may be used in the future unless I specifically notify Dr. Aldo Leopardi in writing that I do not wish the images to be shown.

Acknowledgement of Receipt for Notice of Privacy Policies

___ I have received a copy of Dr. Aldo Leopardi's Notice of Privacy Policies.

I have read and understand the preceding paragraphs.

_____

Patient/Parent or Guardian Date

We will use and disclose protected health information in a manner that is consistent with HIPAA and with our NPP. If we change our NPP, the revised NPP will apply to all protected health information that we have, not just protected health information that we generate or obtain after we have changed the NPP.