MARK R. KAISER, M.D., F.A.A.D.
DIPLOMATE, AMERICAN BOARD OR DERMATOLOGY

Patient: _____

In connection with the medical services that I am receiving from Mark R. Kaiser, M.D., P.A. and its medical staff, I hereby authorize Mark R. Kaiser, M.D., P.A., Dr. Kaiser himself and their respective agents to disclose any information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted disease, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records to:

A. any third party payor covering payment of the medical services of the patient;
B. other health care professionals and institutions involved in the delivery of health care to the patient;
C. the proponent of any legally sufficient subpoena, or response to a court order;
D. employees and agents of the practice, to the degree necessary to facilitate the provisions of health care services and payment for such services;
E. pharmacies; and
F. as otherwise required by law.

I further consent that photographs may be taken of me, or parts of my body, under the following conditions.

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs may be taken by my physician or by a photographer approved by my physician.
3. The photographs will be used for medical records, If in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published or republished, either separately or in connection with each other in professional journals or medical books, or used for any purpose which my physician may deem proper in the interest of medical education knowledge, or research. It is specifically understood that in any such publication or use I will not be identified by name and reasonable steps will be taken to preserve my identity.
4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

When providing information to me, information may be transmitted to me by any or all the following means (initial all that apply):

_____ Telephone messages on an answering machine.
_____ Telephone me at work

I hereby authorize Mark R. Kaiser, M.D., P.A. and its staff to disclose, release or discuss my protected healthcare information to the following family members or friends who may be involved or assist in my care.

_____

Name *Relationship (optional)* *Restrictions*

_____

Name *Relationship (optional)* *Restrictions*

Furthermore, I hereby authorize that below family and friends to provide consent to treatment on my behalf should they accompany any minor child of mine and/or to receive medical information pertaining to me or my minor child.

_____Birthdate: _____

_____Birthdate: _____

In each case, the practice will take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed:_____ Date:_____

Witness:_____