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.

| lease initial each paragraph: | | |
|--|---|--|
| operations, treatment and payment. I hereby authorize Dr. Aldo Leopardi ar condition, both before and after treatment. The and/or printed in journals and publications for patients may view them. Although the images | d staff to take clinical photographs, videos or digital images of my ese images may be presented to scientific, medical and similar group teaching of education purposes. In certain cases, other prospective will not be labeled with my name, I am aware that certain images merty of Dr. Aldo Leopardi and may be used in the future unless I 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 Leop | ardi's Notice of Privacy Policies. | |
| I have read and understand the preceding par- | graphs. | |
| Patient/Parent or Guardian | Date | |
| We will use and disclose protected health infor | mation in a manner that is consistent with HIPAA and with our NP | |

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.