Ali Banki, D.O.
Kristi Krikris, PA-C
Adrianna Pliszka, PA-C
2928 Main Street, Ste 201
Glastonbury, CT 06033

PATIENT CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

Please take a moment to read this abbreviated version of the privacy policies of Dr. Banki's office. If you would like our complete four (4) page HIPAA privacy policies to take home, please indicate by initialing here _____.

With my consent, Dr. Banki's office may call my home or other designated location and leave a message on voicemail or with another person in reference to any items that assist the practice in carrying out my treatment, payment, or healthcare operations. This may be done regarding appointment confirmation or scheduling, insurance issues, account information or clinical care.

With my consent, Dr. Banki's ollice may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminder cards, patient statements and medical information.

By signing this form, I am consenting to Dr. Banki/Kristi Krikris, PA-C/Adrianna Pliszka. PA-C the use and disclosure of my medical information to carry out my treatment, payment, or healthcare operations. If I do not sign this consent, Dr. Banki/ Kristi Krikris, PA-C/Adrianna Pliszka, PA-C may decline to provide treatment to me.

_____ _____

Name of Patient **Date**

_____

Signature of Patient, POA or Legal Guardian (If under the age of 18)

For established minors without a parent or legal guardian at the time of service: I acknowledge I have received a copy of Dr. Banki's Notice of Privacy Practices and this consent form lor my parent or legal guardian's signature. This form is to be returned to the office of Dr'. Banki.

_____ _____

Signature **Date**

BANKI DERMATOLOGY & COSMETIC CENTER