

**Babich Skin Care  
304 West Hay Street  
Decatur, IL 62526**

**Consent for Release and Use of Confidential Information and  
Receipt of Notice of Privacy Practices Form**

I, \_\_\_\_\_ (Name of Patient or Authorized Agent), hereby give my consent to Debra Babich MD to use or disclose, for the purpose of carrying out treatment, payment, or other healthcare operations, all information contained in this patient's record.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change her privacy practices that are described to me in the described Notice.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed \_\_\_\_\_  
Date \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient:

\_\_\_\_\_

**Please check if patient refused to sign consent and initial and date.**

\_\_\_\_\_ Patient refused to sign

Witnessed by

\_\_\_\_\_ Date \_\_\_\_\_