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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

1. With my consent, DERMATOLOGY AND SKIN SURGERY CENTER may use the following methods to communicate with me.
Call to my home or other designated location and leave a message on voicemail or in person, **mail** to my home or other designated location, or **email** to my home or other designated location.
2. I also understand and consent that my personal health information may be disclosed to other appropriate entities, such as (but not limited to) my insurance company (ies), other physicians or health care providers and others as indicated in the Notice of Privacy Practices.
3. I have the right to request that DERMATOLOGY AND SKIN SURGERY CENTER restricts how it uses or discloses my personal health information. I request the following restrictions(s):

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The above restrictions ARE, ARE NOT agreed to by DERMATOLOGY AND SKIN SURGERY CENTER.

Signed: _____ Position/Title: _____ Date: _____

4. If I do not sign this consent, DERMATOLOGY AND SKIN SURGERY CENTER may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form I am consenting to DERMATOLOGY AND SKIN SURGERY CENTER Use and disclose of my personal health Information (PHI) to carry out treatment, Payment, and operations (TPO).

I also authorize assignment of insurance benefits to DERMATOLOGY AND SKIN SURGERY CENTER.

Signature of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Patient's or Guardian's Printed Name

Date