



Dermatology & Skin Surgery Center

Dermatology & Skin Surgery Center, PC - 210 Village Center Pkwy - Stockbridge, GA 30281

Dr. Maria Pico - Dr. Neville Pereyo - Dr. Brenda Morales - Dr. Nicole Rochet - Dr. David Pharis
Matthew Brunner, PA-C - Christopher Golden, PA-C - Vanessa Winokur, PA-C - Lisa Weiss, PA-C

HIPAA PATIENT CONSENT

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 & SKIN SURGERY CENTER, PC** 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, and/or
 - **E-mail** 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 & SKIN SURGERY CENTER, PC** restricts how it uses or discloses my personal health information. I request the following restriction(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 & SKIN SURGERY CENTER, PC.

Signed: _____ Position/Title: _____ Date: _____

4. If I do not sign this consent, DERMATOLOGY & SKIN SURGERY CENTER, PC 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 & SKIN SURGERY CENTER, PC's use and disclosure of my personal health information (PHI) to carry out treatment, payment, and operation (TPO).

I also authorize assignment of insurance benefits to DERMATOLOGY & SKIN SURGERY CENTER, PC

Signature of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Patient or Guardian's Printed Name

Date

DERMATOLOGY & SKIN SURGERY CENTER, LLP reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ms. Dean Height, Privacy Office at 210 Village Center Pkwy, Stockbridge, GA 30281

Patient PHI Consent
Effective 11/15/03
HIPPA Form revised 8/2013