Advanced Dermatology and Skin Surgery

Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Advanced Dermatology to use and disclose **protected health information** (PHI) about me to carry out **treatment, payment and healthcare operations** (TPO).

Advanced Dermatology's **Notice of Privacy Practices** provides a more complete description of such uses and disclosures.

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

Advanced Dermatology 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 Advanced Dermatology and Skin Surgery, Privacy Officer at: 16 Medical Park Drive, Asheville, NC 28803.

With this consent, Advanced Dermatology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Advanced Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long a they are marked Personal and Confidential.

With this consent, Advanced Dermatology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advanced Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Advanced Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Dermatology may decline to provide treatment to me.

We appreciate your understanding and cooperation

Advanced Dermatology and Skin Surgery

Signature of Patient/Legal Guardian
Consent for Use and Disclosure
Of Protected Health Information

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Signature of Patient or Legal Guardian

____________________________________ ____________________
Print Name of Patient or Legal Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Dermatology and Skin Surgery reserves the right to modify the privacy practices outlines in the notice.

I have received a copy of the Notice of Privacy Practices for Advanced Dermatology and Skin Surgery.

_________________________________ ___________________________________
Name of Patient (Print) Signature of Patient

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Date

_________________________________ ___________________________________
Signature of Patient Representative Relationship to Patient
(Required if the patient is a minor or an adult who is unable to sign this form.)

Please list the family members or other persons, if any, whom we may discuss your general medical condition in case of an emergency, appointment call (i.e. verifying appointments, appointment changes) and questions regarding your bill.

Name_____________________________ Phone Number_________________________________

Name_____________________________ Phone Number_________________________________

Please print the telephone number where you want to receive calls about your appointments, lab and biopsy results, or other health care information if other than your home phone number:
________________________.