DERMATOLOGY AND SKIN SURGERY CENTER, PA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dermatology and Skin Surgery Center, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology and Skin Surgery Center, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have reviewed the Notice of Privacy Practices prior to signing this consent. Dermatology and Skin Surgery Center, PA 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 Dean R. Goodless, MD, Privacy Officer at Dermatology and Skin Surgery Center, PA, PO Box 470396, Celebration, FL 34747.

With my consent, Dermatology and Skin Surgery Center, PA may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

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

With my consent, Dermatology and Skin Surgery Center, PA may e-mail to my home or other designated 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 Dermatology and Skin Surgery Center, PA 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 Dermatology and Skin Surgery Center, PA'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.

______________________________	______________________________
Signature of Patient or Legal Guardian	Staff Signature (patient notified of privacy policy but refuses to sign)
______________________________	______________________________
Patient's Name	Staff Name
______________________________	__________________
Print Name of Patient or Legal Guardian	Date

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