DERMATOLOGY ASSOCIATES, PSC

Patient Information

Dermatology Associates, PSC
2811 Klempner Way
Louisville KY 40205

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dermatology Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation. (TPO). Please refer to Dermatology Associates Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the above address.

With my consent, Dermatology Associates may call my home or other designated location and leave a message on a 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 Associates may discuss the details of my laboratory results with the following (patient to initial each authorization box):
❐Parent(s) ❐Step-Parent(s) ❐Spouse ❐Other (please list)________________

With my consent, Dermatology Associates may inform me of the details of my laboratory results via the following methods in addition to personally discussing the results with me:
❐Home Answering Machine ❐Voice Mail (list phone number/ext.)______________
❐Email (address)______________ ❐Other (please list) ________________

With my consent, Dermatology Associates 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 and laboratory results.

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, Dermatology Associates, may decline to provide treatment to me.

Patient's Name ____________________________ Date ____________________
Signature of Patient or Legal Guardian ____

Email Disclosure

I give consent to Dermatology Associates to e-mail to my home or other designated location any items that assist the practice in carrying out TPO, and the disclosure of PHI, such as appointment reminder cards and patient statements, insurance items and any information pertaining to my clinical care including laboratory results among others. I have the right to a written request that Dermatology Associates restrict how it uses or discloses my PHI to carry out TPO. The practice will inform in writing if my request will be granted. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Signature of Patient or Legal Guardian _____________________ Date _________________

Employee Initials ___