DERMATOLOGY ASSOCIATES, PSC

[redacted]

2811 Klempner Way
Louisville, KY 40205

Patient Information

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): ❒ **Only discuss account with patient**

❒Parent(s)/Guardian ❒Step-Parent(s) ❒Spouse (name) _____

❒Other (please list name & relationship)_____

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 phone answering machine/voicemail ❒ Cell phone voice mail ❒ **No messages with details**

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.

With my consent, Dermatology Associates may e-mail (if my email was provided) any items that assist the practice in carrying out TPO, and the disclosure of PHI, such as appointment reminders, patient statements, insurance items and any information pertaining to my clinical care including laboratory results. 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.

Patient's Name (printed) _____ Date _____

Signature of Patient/Legal Guardian _____

Relationship if not patient _____