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*Board Certified Dermatologists
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DERMATOLOGIC LASER CENTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for the Dermatologic Laser Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (the Dermatologic Laser Center'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. The Dermatologic Laser Center 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 the Dermatologic Laser Center Privacy Officer at 2310 Randolph Rd, Charlotte, NC, 28207.

With this consent, the Dermatologic Laser Center 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 treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Dermatologic Laser Center may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as patient statements as long as they are marked Personal and Confidential.

With this consent, the Dermatologic Laser Center may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders and patient statements. I have the right to request that the Dermatologic Laser Center restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. 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 the Dermatologic Laser Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

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, the Dermatologic Laser Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian