Patient Consent for Use and Disclosure of Protected Health Information

WINSTON SALEM DERMATOLOGY & SURGERY CENTER, PLLC

I hereby give my consent for Winston Salem Dermatology & Surgery Center, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Winston Salem Dermatology & Surgery 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. Winston Salem Dermatology & Surgery 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 Winston Salem Dermatology & Surgery Center, Attn: Privacy Officer at 1400 Westgate Center Drive, Suite 200, Winston-Salem, NC 27103.

With this consent, Winston Salem Dermatology & Surgery 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory/pathology results among others. **Should we need to speak with you concerning laboratory results, pathology results, appointments, insurance items or general information, and cannot reach you, may we leave a message? □ Yes □ No**

Please list approved telephone numbers: ______________________________ ______________________________

______________________________ ______________________________

With this consent, Winston Salem Dermatology & Surgery Center, may disclose my PHI 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 to the following individuals.

______________________________ ______________________________

Name and Relationship Name and Relationship

______________________________ ______________________________

Name and Relationship Name and Relationship

With this consent Winston Salem Dermatology & Surgery Center, 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 as they are marked Personal and Confidential.

With this consent, Winston Salem Dermatology & Surgery Center, 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. Please list approved email: ____

I have the right to request that Winston Salem Dermatology & Surgery Center, 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 Winston Salem Dermatology & Surgery Center'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, Winston Salem Dermatology & Surgery Center, may decline to provide treatment to me.

______________________________ ______________ ______________

Patient's Name Date of Birth Today's Date

______________________________ ______________________________

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian