PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Family Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Family Dermatology Notice of Privacy Practices for 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. Family Dermatology 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 Family Dermatology management.

With my consent, Family Dermatology 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, Family Dermatology may communicate with me via SMS/Text or iMessage 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, Family Dermatology 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.

CHECK ONE

- ○ With my consent, I hereby give Family Dermatology permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with ______________________
  [Relationship to patient: ______________________] Contact Phone # ______________
  Please initial: ________
- ○ I choose not to give consent to Family Dermatology to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Family Dermatology.

By signing this form, I am consenting to Family Dermatology use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Family Dermatology Notice of Privacy Polices.

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, Family Dermatology may decline to provide treatment to me.

Results notification will be primarily through the patient portal for benign or normal pathology/lab results. Benign or normal reports will be uploaded to your portal once reviewed by your provider and you will receive an email informing you when your report(s) have been uploaded. We will call you at your provided phone number(s) for any abnormal results or those that require further explanation. If you wish to opt out of portal notifications, you must do so in writing.

______________________________ ______________________________

Signature of Patient or Legal Guardian — Name of Legal Guardian (if applicable)

______________________________ ___/___/___ ___/___/___

Patient's Name — Patient DOB — Date Signed

Family Dermatology

Damage Disclaimer

Family Dermatologyy cannot be held responsible for personal property brought or worn by the patient onsite that is lost, stolen, or damaged while the patient is on the premises or parking areas for the premises.

All patients are encouraged to exercise proper care in securing all belongings or protecting belongings from damage.

I have read the above and understand my responsibility.

____
Patient Signature

____
Printed Name

____
Date