Patient Consent for Use and Disclosure of Protected Health Information
And
Receipt of Notice of Privacy Practices Written Acknowledgement Form

East Penn Dermatology, P.C.
1140 Welsh Road, Suite 130
North Wales, PA 19454

Patient Name: _____ DOB: _____

I hereby give my consent for East Penn Dermatology, P.C. to use and disclose **protected health information** (**PHI**) about me to carry out **treatment, payment and healthcare operations** (**TPO**). East Penn Dermatology, P.C.'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. East Penn Dermatology, P.C. 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 East Penn Dermatology, P.C., and Attention Privacy Officer at 1140 Welsh Road, Suite 130, North Wales, PA 19454.

With this consent, East Penn Dermatology, P.C. 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 results among others.

With this consent, East Penn Dermatology 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, East Penn Dermatology, P.C. 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.

I have the right to request that East Penn Dermatology, P.C. 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.

I hereby acknowledge receipt of East Penn Dermatology, P.C.'s Notice of Privacy Practices.

By signing this form, I am consenting to East Penn Dermatology, P.C.'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, East Penn Dermatology, P.C. may decline to provide treatment to me.

_____ PATIENT / PARENT / LEGAL GUARDIAN / POA

Signature of Patient or Legal Guardian Date RELATIONSHIP TO PATIENT (CIRCLE ONE)

_____

Print Name of Patient or Legal Guardian

Form Dated 8/21/2013