Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Southern Skies Dermatology and Surgery may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Southern Skies Dermatology and Surgery 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. Southern Skies Dermatology and Surgery reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by request to Southern Skies Dermatology and Surgery.

With my consent, Southern Skies Dermatology and Surgery 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 but not limited to laboratory results.

With my consent, Southern Skies Dermatology and Surgery may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as laboratory and pathology results, appointment reminder cards and patient statements.
With my consent, Southern Skies Dermatology and Surgery may e-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. I have the right to request that Southern Skies Dermatology and Surgery restrict how it uses or discloses my PHI to carry out its clinical care. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

During the course of your medical treatment, we strive to communicate with you, the patient, in a timely and professional manner. There are certain occasions when family members, friends, or others might be involved in your care and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please indicate below the names of any other people with whom we can discuss your care and personal health information:

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

Name:_____ DOB_____Relationship_____

By signing this form, I am consenting to Southern Skies Dermatology and Surgery'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 his consent, Southern Skies Dermatology and Surgery may decline to provide treatment to me.

Signature of Patient/Legal Guardian:_____Date:_____

Relationship to Patient if Legal Guardian:_____