PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Raleigh Dermatology Associates/Skin & Cosmetic Solutions, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Raleigh Dermatology Associates/Skin & Cosmetic Solutions, 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.

Raleigh Dermatology Associates/Skin & Cosmetic Solutions, 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 Raleigh Dermatology Associates, P.A., ATTN: Privacy Officer at 800 Springfield Commons Drive, Suite 115, Raleigh, NC, 27609.

With my consent, Raleigh Dermatology Associates/Skin & Cosmetic Solutions, 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, billing information and any call pertaining to my clinical care, including laboratory results, treatment plans, condition updates among others.

With my consent Raleigh Dermatology Associates/Skin & Cosmetic Solutions, 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.

I have the right to request that Raleigh Dermatology Associates/Skin & Cosmetic Solutions 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 Raleigh Dermatology Associates/Skin & Cosmetic Solutions, 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, Raleigh Dermatology Associates/Skin & Cosmetic Solutions, may decline to provide treatment to me.

Raleigh Dermatology Associates/Skin & Cosmetic Solutions is not permitted, by law, to provide medical information to anyone other than the patient except for treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

Please complete the following so that the individuals you specify can have access to your information as described above.

I, _____, as a patient of Raleigh Dermatology Associates/Skin & Cosmetic Solutions, authorize the release of my medical information regarding my treatment and care to the following individuals upon their request:

_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number
_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number

By signing below I authorize Raleigh Dermatology Associates/Skin & Cosmetic Solutions to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Raleigh Dermatology Associates/Skin & Cosmetic Solutions describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time.

_____	_____
Patient's Name	Date of Birth
_____	_____
Signature of Patient (Legal Guardian)	Date