ANNAPOLIS DERMATOLOGY CENTER, PA

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Patient Consent for Use and Disclosure of Protected Health Information for Annapolis Dermatology Center

With my consent, Annapolis Dermatology Center, may use and disclose **protected health information** (PHI) about me to carry out **treatment, payment** and **health care operations** (TPO). Please refer to the 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.

Annapolis Dermatology Center reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Annapolis Dermatology Center** Privacy Officer at 71 Old Mill Bottom Road, North, Suite 300, Annapolis, MD 21409.

With my consent, **Annapolis Dermatology Center** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists the practice 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, **Annapolis Dermatology Center** 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.

With my consent, **Annapolis Dermatology Center** 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 **Annapolis Dermatology 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 **Annapolis Dermatology Center** use and disclosure of my PHI and 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, **Annapolis Dermatology Center** may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____

Patient's Name _____ Date _____

Print Name of Patient or Legal Guardian _____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

_____

Annapolis Dermatology Center

I am a patient of Annapolis Dermatology Center. I hereby acknowledge receipt of Annapolis Dermatology Center's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Annapolis Dermatology Center's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____