ALAMANCE DERMATOLOGY, P.A
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent of Alamance Dermatology, P.A. to use and disclosure protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Alamance Dermatology, P.A.'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. Alamance Dermatology, P.A. 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: Privacy Officer at Alamance Dermatology, P.A., 1638 Memorial Drive, Burlington, NC 27215.

With this consent, Alamance Dermatology, P.A., 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 calls pertaining to my clinical care.

- 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 CONFIDENTIAL.

- 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 Alamance Dermatology, P.A. 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 may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Alamance Dermatology may decline to provide treatment to me.

By signing this form, I am consenting to Alamance Dermatology, P.A. use and disclosure of my PHI to carry out TPO as described above unless otherwise noted below. I have received a copy of Alamance Dermatology, P.A.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Print Legal Guardian's Name if minor

Restrictions to agreement: _____

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