SOUTH TEXAS DERMATOLOGY

PATIENT **C**ONSENT FOR USE AND DISCLOSURE OF **P**ROTECTED **H**EALTH **I**NFORMATION

With my consent, South Texas Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to South Texas Dermatology's 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. South Texas Dermatology 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 Jennifer Vincent, Office Manager at 4141 S. Staples suite 300, Corpus Christi, Texas 78411.

With my consent, South Texas Dermatology 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 laboratory results among others.

With my consent, South Texas Dermatology 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, South Texas Dermatology may e-mail to my home or 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 South Texas Dermatology 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 beyond this agreement.

By signing this form, I am consenting to South Texas Dermatology'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, South Texas Dermatology may decline to provide treatment to me based on my decision not to comply with their PHI Policy.

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Signature of Patient or Legal Guardian

_____ _____
Signature of Patient Date

_____
Print Name of Patient or Legal Guardian