DERMATOLOGY CONSULTANTS

Dermatology Consultants, P.C.

General, Surgical, & Cosmetic Dermatology

Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Dermatology Consultants, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dermatology Consultants, P.C.'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. Dermatology Consultants, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology Consultants, P.C. Privacy Officer at 2045 Peachtree Road, Suite 200, Atlanta, Georgia 30309.

With this consent, Dermatology Consultants, P.C. 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 any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, Dermatology Consultants, P.C. may 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 Personal and Confidential.

With this consent, Dermatology Consultants, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Dermatology Consultants, P.C. 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 Dermatology Consultants, P.C.'s use and disclosures 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, or later revoke it, Dermatology Consultants, P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

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Consent to Share Information

I authorize Dermatology Consultants, P.C. to disclose medical information pertaining to payments, insurance, diagnosis, and my personal health to the following persons:

Name	Phone Number	Leave a Detailed Message (circle)
_____	_____	Yes No
_____	_____	Yes No

Relation to patient:_____

**The above will stay in effect until voided by you.*

Patient Name *(Please Print)*_____ Date of Birth: _____

Patient/Responsible Party Signature:_____ Date: _____

Pharmacy Information

Patient Name: _____ Date of Birth: _____

Dermatology Consultants, P.C. is enrolled in an electronic prescribing program. This program is meant to help our providers understand what medications our patients are currently using in order to provide the best possible treatment. By signing this consent form you are agreeing that Dermatology Consultants, P.C. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Dermatology Consultants, P.C. enroll me in the ePrescribe program.

_____ _____

Signature of Patient or Representative Date:

Pharmacy Name:_____

Address *(or cross streets and town)*: _____

Phone Number: _____

2045 Peachtree Road, NE • Suite 200 • Atlanta, Georgia 30309 • (404) 351-7546

4800 Olde Towne Parkway • Suite 250 • Marietta, GA 30068 • (770) 971-3376

4151 Hospital Drive • Covington, Georgia 30014 • (770) 784-0343