Alabama Dermatology Associates
Medical, Surgical and Cosmetic Skin Care Specialists

Patient Consent for Use and Disclosure of Protected Health Information and Receipt of Notice of Privacy Practices

With my consent, Alabama Dermatology Associates, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Alabama Dermatology Associate'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. Alabama Dermatology Associates reserves the right to revise its Notice of Privacy Practices at Alabama Dermatology Associates anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at 4410 Watermelon Road, Northport, AL 35473. With my consent, Alabama Dermatology Associates may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Alabama Dermatology Associates 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 as long as they are marked Personal and Confidential. I have the right to request that Alabama Dermatology Associates 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 Alabama Dermatology Associates 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, Alabama Dermatology Associates may decline to provide treatment to me.

We may communicate with you concerning your protected health information via email or texting. We also may leave detailed messages on your answering machine or voicemail. Please check the boxes below if you do not want us to use these communication methods.

- ☐ Do not communicate with me concerning my protected health information via email or texting.
- ☐ Do not leave detailed messages concerning my protected health information on my answering machine or voicemail.

Email address: _____

Please list the names of the people with whom we may communicate concerning your protected health information:

Name	Relationship	Telephone #

Restrictions Requested: _____

_____

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian