

Hill Country Dermatology, P.A.

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Hill Country Dermatology, P.A. (Dermatology Practice), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to this Dermatology Practice Notice of Privacy Practices for a more complete description of such used and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hill Country 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 Dermatology Practicer Privacy Officer at 95 E. Highway St., Fredericksburg, TX 78624.

With my consent, Hill Country Dermatology, P.A. 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, Hill Country Dermatology, P.A. may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Hill Country Dermatology, P.A. 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 Hill Country Dermatology, P.A. restrict how it uses or discloses my PHI to carry out TPO.

However, Hill Country Dermatology, P.A. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

(OVER)

By signing this form, I am consenting to Hill Country Dermatology, P.A. to 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, Hill Country Dermatology, P.A. may decline to provide treatment to me.

DO NOT SIGN DO NOT SIGN

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian