

Montgomery Dermatology, LLC

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Montgomery Dermatology, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Montgomery Dermatology, LLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been offered a copy of the Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. Montgomery Dermatology, LLC 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 491 Allendale Road, Suite 302, King of Prussia, PA 19406.

WITH MY CONSENT, Montgomery Dermatology, LLC may call my home or other designated location and leave a message on my answering machine 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 but not restricted to benign (normal) biopsy and laboratory results.

WITH MY CONSENT, Montgomery Dermatology, LLC 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. I have the right to request that Montgomery Dermatology, LLC restrict how it uses my PHI to carry out TPO.

Complicated or benign laboratory and/or biopsy results **may be discussed** with the following family members:

_____ Relationship _____

_____ Relationship _____

IF YOU DO NOT GIVE CONSENT PLEASE CHECK ALL THE BOXED BELOW THT APPLY:

- Do not leave normal lab and/or biopsy results with family members or on answering machine
- Do not discuss any lab and/or biopsy results with anyone but the patient or the patient's parent if the patient is a minor.

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 Montgomery Dermatology, LLC'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, Montgomery Dermatology, LLC may decline to provide treatment to me.

Signature of Patient and/or Legal Guardian

Date

Printed Name of Patient and/or Legal Guardian