Montgomery Dermatology, LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Montgomery Dermatology, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Montgomery Dermatology, LLC'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. Montgomery Dermatology, LLC reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Montgomery Dermatology, LLC Privacy Officer at 860 First Avenue, Suite 8B, King of Prussia, PA 19406. With this consent, Montgomery Dermatology, LLC 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, Montgomery Dermatology, LLC 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. I have the right to request that Montgomery Dermatology, LLC 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 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, or later revoke it, Montgomery Dermatology, LLC may decline to provide treatment to me.

Signature: _____ Date: _____

Patient or Legal Guardian

Patient's Name: _____ Date: _____

Printed Name of Patient or Legal Guardian: _____