



**Georgia Dermatology Center  
Patient Consent for Use and Disclosure  
Of Protected Health Information**

With my consent, Georgia Dermatology Center may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

- Please refer to Georgia Dermatology Center'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. Georgia Dermatology Center reserves the right to revise its Notice of Privacy Practices at any time with written request to Georgia Dermatology Center Privacy Officer at 1505 Northside Blvd. Suite 1500, Cumming, GA 30041.
- With my consent, Georgia Dermatology Center 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, financial information, and any call pertaining to my clinical care, including laboratory results and medical information among others .

You may discuss with my: \_\_\_\_\_ Whose name is: \_\_\_\_\_

- With my consent, Georgia Dermatology Center 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.
- With my consent, Georgia Dermatology Center 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 and financial information.
- I have the right to request that Georgia Dermatology Center 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 Georgia Dermatology Center'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, Georgia Dermatology Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Patient or Legal Guardian: \_\_\_\_\_