COASTAL DERMATOLOGY & SKIN CANCER CENTER

Patient Consent For Use and Disclosure Of Protected Health Information

With my consent, Coastal Dermatology & Skin Cancer Center (hereinafter referred to as CDSCC) may use and disclose protected health information (hereinafter referred to as PHI) about me to carry out treatment, payment, and healthcare operations (hereinafter referred to as TPO). Please refer to CDSCC'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. CDSCC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CDSCC Privacy Officer at: P.O. Box 494710, Port Charlotte, FL 33949.

With my consent, CDSCC 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, CDSCC 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, CDSCC 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 CDSCC 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 CDSCC'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, CDSCC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Name of Patient or Legal Guardian

Patient's Name: _____ **Date of Birth:** _____