PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Northeast Dermatology Associates [NEDA] may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Dermatology Associates' **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. Northeast Dermatology Associates 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 Northeast Dermatology Associates' Chief Privacy Officer at [*280 Merrimack St, #311, Lawrence, MA 01843*].

With my consent, Northeast Dermatology Associates 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, Northeast Dermatology Associates 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.

CHECK ONE

○ With my consent, I hereby give Northeast Dermatology Associates permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with _____

[Relationship to patient:_____] Contact Phone # _____

Please initial: _____

○ I choose not to give consent to NEDA to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Northeast Dermatology.

By signing this form, I am consenting to Northeast Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Northeast Dermatology's Notice of Privacy Polices.

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, Northeast Dermatology Associates may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Legal Guardian (if applicable)

_____ ____/____/_____ _____

Patient's Name Patient DOB Date Signed

Emergency Contact Information

Emergency Contact Name: _____

Phone Number: _____

Relationship to patient: _____

Today's Date: _____