Vacaville Dermatology, A Medical Corporation
941 Merchant St, Suite A, Vacaville, CA 95688

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Vacaville Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Vacaville Dermatology's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have received a copy of Vacaville Dermatology's Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Vacaville Dermatology 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 Vacaville Dermatology Privacy Officer at 941 Merchant Street, Suite A, Vacaville, CA 95688.

With this consent, Vacaville Dermatology 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 and biopsy/pathology results among others.

With this consent, Vacaville Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and laboratory and biopsy/pathology results among others.

With this consent, Vacaville Dermatology may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and laboratory and biopsy/pathology results among others.

I have the right to request that Vacaville Dermatology 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 Vacaville Dermatology'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, Vacaville Dermatology may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

________________________________ ____________________
Patient's Name Date

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Print Name of Patient or Legal Guardian