Princeton Dermatology Associates (PDA)

HIPAA / Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for PDA to use and disclose Protected Health Information (PHI) about me in order to carry out health care treatment and payment operations. (The Notice of Privacy Practices provided herein by PDA describes such uses and disclosures more completely. To learn more about HIPAA, you may visit the website for the US Department of Health and Human Services at: http://www.hhs.gov/ocr/privacy)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

PDA 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 request to PDA.

With this consent I agree and acknowledge that PDA may:

- Call, email, text, and/or leave messages on voice mail at the numbers and email I have provided PDA regarding appointment reminders, insurance and billing items, and any other matters pertaining to my clinical care, including test results, etc.

- Speak to certain person(s) regarding any appointment reminders, insurance items, and any matters pertaining to my clinical care, including test results, etc. (Please list on the line below the name of family members or other person(s) with whom we may speak. Should you wish we only speak to you regarding your PHI, please state "Patient only") _____

- Mail to my home address any items that may assist the practice in carrying out treatment, payment, and health care operations.

- Send electronic medication prescriptions to my pharmacy, and when available obtain medication history records to be downloaded into my electronic medical record.

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 if I later revoke it, PDA may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal Guardian | Print Patient's Name | Patient's Date of Birth

_____ _____

Print Name of Patient's Legal Guardian, if applicable | Date

(The Patient/Legal Guardian my request a photocopy of this signed consent)