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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Perimeter Dermatology, P.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Perimeter Dermatology P.C.**'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**. Perimeter Dermatology, P.C.** 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 **Perimeter Dermatology P.C.'s** Privacy Officer at **[5505 Peachtree Dunwoody Rd, Suite 412, Atlanta, GA 30342].**

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, and patient statements as long as they are marked Personal and Confidential.

Perimeter Dermatology, P.C. restricts 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 Perimeter Dermatology P.C.'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, **Perimeter Dermatology, P.C.** may decline to provide treatment to me.

I authorize the following individuals to have access to health information:
_____
_____

_____ _____
Patient Name **Date**

_____ _____
Patient/Guardian Signature **Print name Patient/Guardian Signature**

Authorization for additional disclosure:
I am the "personal representative" of (generally parent/legal guardian) and have legal authority to make health care decisions about the following minor patient(s):_____.
Print Name(s)
As the "personal representative" of the above named patient(s), I authorize the following individuals to accompany my child for treatment and have access to health information.
Name and Relationship to patient(s)

1) _____
2) _____
3) _____
4) _____