Patient Consent for Use and Disclosure of Protected Health Information

With my consent, North Dallas Dermatology Associates (NDDA) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to North Dallas Dermatology Associate's Notice of Privacy Practices for a more complete description of such uses and disclosures.

NDDA reserves the right to revise its Notice of Privacy Practices at anytime. If you have any questions regarding this notice or our health information privacy policies and would like to receive a revised notice, please contact the Privacy Officer by forwarding a written request to North Dallas Dermatology Associates Privacy Officer at 9301 N. Central Expressway, Suite 180, Dallas, Texas 75231.

With my consent, NDDA may call my home, office, cell phone or other designated number(s) 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 and pathology results, among others.

With my consent, NDDA 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.

I have the right to request that NDDA 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 NDDA's use and disclosure of my PHI to conduct treatment, payment, and healthcare operations (TPO).

I understand that I am responsible for payment of professional services at the time they are rendered, unless alternative arrangements have been made in advance. This includes all co-payments and deductibles.

I certify that I am the patient or the parent / legal guardian of the patient, and I consent to treatment necessary for the care of the patient indicated on this form.

I hereby authorize NDDA to release any medical or incidental information that may be necessary for medical care or in processing of medical insurance claims.

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, NDDA may decline to provide treatment to me.

I hereby acknowledge that I reviewed the Notice of Privacy Practices for North Dallas Dermatology Associates.

______________________________ ____________________
Signature Date

______________________________ ____________________
Relationship Name of Patient