

CONSENT FORM
**(For Use and Disclosure of Protected Health Information for Treatment, Payment,
or Healthcare Operations)**

I understand that as part of my healthcare, *Blue Ridge Dermatology Associates, P.A. (BRDA)* originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Posted for my review is the **Notice of Information Practices**. I understand that the **Notice of Information Practices** provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, *BRDA* 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 (**T**reatment, **P**ayment, or **H**ealthcare **O**perations), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, *BRDA* may mail to my home or other designated location any items that assist the practice in carrying out TPO (**T**reatment, **P**ayment, or **H**ealthcare **O**perations), such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, *BRDA* may e-mail to me appointment reminders and patient statements. I have the right to request that *BRDA* restrict how it uses or discloses my PHI (**P**rotected **H**ealth **I**nformation) to carry out TPO (**T**reatment, **P**ayment, or **H**ealthcare **O**perations). 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 *BRDA* to use and disclose my PHI (**P**rotected **H**ealth **I**nformation) to carry out my TPO (**T**reatment, **P**ayment, or **H**ealthcare **O**perations).

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, *BRDA* may decline to provide treatment to me.**

Print Patient Name: _____

Signature of Patient: _____, or

Signature of Legal Guardian: _____ (if patient is under 18 years of age)

Date: _____