

**Patient Preferred Dermatology Medical Group, Inc.**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

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

I have the right and the opportunity to review the Notice of Privacy Practices prior to signing this consent. Patient Preferred Dermatology Medical Group, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Patient Preferred Dermatology Medical Group, Inc. Privacy Officer at 3772 Katella Ave. #206, Los Alamitos, CA 90720

With my consent, Patient Preferred Dermatology Medical Group, Inc. 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, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Patient Preferred Dermatology Medical Group, Inc. 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.

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 Patient Preferred Dermatology Medical Group, Inc.'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, Patient Preferred Dermatology Medical Group, Inc. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date