PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, George Dermatology may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO)(available upon request). Please refer to the George Dermatology Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and Notice of Privacy Practices prior to signing the consent. George Dermatology 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 the Privacy Officer at 12255 DePaul Drive, #770N, Bridgeton, MO 63044.

With my consent, George Dermatology may e-mail, fax, mail or verbally send to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment card reminders, financial or medication information. I have the right to request that George Dermatology restrict how it uses or discloses my PHI to carry out TPO'. However, the practice is not required to agree to my required restrictions, but if it does it is bound by this agreement.

E-Mail Address: _____

I authorize the release of medical information necessary to process my claim and also authorize payment of medical benefits to George Dermatology. I understand that I am responsible for any and all balances left after insurance pays. I will be responsible for all balances if I do not have insurance.

By signing this form I am consenting to George Dermatology's use and disclosure of my PHI or carry out TPO.

I may revoke my consent in writing expect to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, George Dermatology may decline to provide treatment to me. With my consent, Dr. George and/or staff may call my home or other designated locations and leave a message on voicemail.

If I am unavailable, I give Dr. George and/or staff consent to discuss my medical or financial status with:

_____

(include names, relationship and phone number)

_____

Signature of patient or legal guardian Date