AIKEN DERMATOLOGY AND SKIN CANCER CLINIC
Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, Aiken Dermatology and Skin Cancer Clinic may use and disclose **Protected Health Information** (PHI) about me to carry out **Treatment, Payment and Healthcare Operations** (TPO). Please refer to Aiken Dermatology'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. Aiken Dermatology and Skin Cancer Clinic 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 Aiken Dermatology at 1520 Two Notch Rd, Aiken, SC 29803.

With my consent, Aiken Dermatology 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, Aiken Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, cards and patient statements.
With my consent, Aiken Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Aiken Dermatology 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 Aiken Dermatology's use and disclosure of my PHI (Protected Health Information) to carry out TPO (Treatment, Payment and Healthcare Operations).
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, Aiken Dermatology and Skin Cancer Clinic may decline to provide treatment to me.

I give permission to discuss my Financial Information with: _____
(Family member/Friend)

I give permission to discuss my Medical Information with: _____
(Family member/Friend)

Patient Name:_____ Date:_____

Signature of Patient or Legal Guardian:_____

Print Name of Patient or Legal Guardian:_____