Aesthetic Dermatology, PA

David L Allyn, MD ~ Board Certified Dermatology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Aesthetic Dermatology, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Aesthetic Dermatology, P.A.'s Notice of Privacy Practices provides a more complete description detailing how my information may be used and disclosed as permitted under law.

I have received/reviewed the HIPAA Notice of Privacy Practices prior to signing this consent and Aesthetic Dermatology, P.A. 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:

Aesthetic Dermatology, P.A. Attn: Privacy Officer
210 North Highway, Suite 1, Clermont, Florida 34711

With this consent, Aesthetic Dermatology, P.A. may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, Aesthetic Dermatology, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked *Personal and Confidential*.

With this consent, Aesthetic Dermatology, P.A. may e-mail to my home or other alternative 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 in writing that Aesthetic Dermatology, P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Aesthetic Dermatology, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing hereafter for the Notice of Privacy Practices. If I do not sign this consent, or later revoke it, Aesthetic Dermatology, P.A. may decline to provide me treatment.

Authorization to Release Medical Information (PHI) and Emergency Contact Person

I herein give my permission for Aesthetic Dermatology, P.A. to disclose any pertinent information regarding my medical records/ Protected Health Information (PHI) to the person(s) listed below to ensure my continuity of care. I hereby release Aesthetic Dermatology, P.A. from any and all liability which may result from the use of any such information. In case of emergency, I give my permission to contact the designated name(s) below.

Name(s) of Authorized Person(s) and Phone Number:	Relationship to Patient	Note if an **Emergency Contact**
1.		
2.		
3.		

Academic Facility Notification: I understand that Aesthetic Dermatology, P.A. is affiliated with various medical programs and schools. There may be physicians, physician assistants, residents or students that may observe, assist or provide medical care and treatment along with Dr. Allyn and Aesthetic Dermatology, P.A. Should you receive medical care at this facility from a physician, physician assistants, residents or students, any liability that may arise from their care is limited to the school or programs comprehensive professional liability or other insurance. There may also be other medical training programs, student observers and/or "non-medical" staff at Aesthetic Dermatology, P.A. also observing or assisting Dr. Allyn and Aesthetic Dermatology, P.A.

To **decline** this section please initial and notify staff: _____

Patient Signature (Parent or Legal Guardian, if minor): _____

Print Name: _____ Date: _____