Mid-Charlotte Dermatology
Southeast Vulvar Clinic

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Mid-Charlotte Dermatology/Southeast Vulvar Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to Mid-Charlotte 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. Mid-Charlotte Dermatology/Southeast Vulvar Clinic reserves the right to revise its notice of privacy practices at anytime. A reviewed notice of privacy practices may be obtained by forwarding a **written request** to 6406 Carmel Road, Unit 309, Charlotte, NC 28226.

I have the right to request that Mid-Charlotte Dermatology/Southeast Vulvar Clinic restrict how it uses or disclosed my personal healthcare information. 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 Mid-Charlotte Dermatology/Southeast Vulvar Clinic's use and disclosure of my personal healthcare information.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance up on prior consent. If I do not sign this contract, Mid-Charlotte Dermatology/Southeast Vulvar Clinic **may decline to provide treatment for me.**

With my consent, Mid-Charlotte Dermatology/Southeast Vulvar Clinic may discuss with:

Name	**Relationship**
Name	**Relationship**
Name	**Physician/Healthcare Provider**
Name	**Primary Care Provider**

other elements of my condition as may be necessary to assist the practice in carrying out my healthcare and treatment needs.

Signature	Date
Print Name of Patient	
Signature of Legal Guardian	Print Name of Legal Guardian