MID-CHARLOTTE DERMATOLOGY AND RESEARCH
SOUTHEAST VULVAR CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Mid-Charlotte Dermatology and Research, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mid-Charlotte Dermatology and Research's notice of privacy policies 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 and Research, PLLC 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 Mid-Charlotte Dermatology's privacy officer at 4335 Colwick road Suite D Charlotte, North Carolina 28211.

With my consent, Mid-Charlotte Dermatology and Research, PLLC 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, Mid-Charlotte Dermatology and Research, PLLC 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 as long as they are marked personal and confidential.

I have the right to request that Mid-Charlotte Dermatology and Research, PLLC 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 Mid-Charlotte Dermatology and Research'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 contract, Mid-Charlotte Dermatology and Research, PLLC may **decline to provide treatment to me.**

_____
PATIENT NAME

_____ _____
PRINT NAME OF PATIENT OR LEGAL GUARDIAN DATE

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

With my consent, Mid-Charlotte Dermatology and Research, PLLC may discuss with:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

other elements of my condition as may be necessary to assist the practice in carrying out TPO