

**DERMATOLOGY SPECIALISTS OF NORTH ATLANTA, P.C.**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Dermatology Specialists of North Atlanta, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dermatology Specialists of North Atlanta’s Notice of Privacy Practices provides 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. Dermatology Specialists of North Atlanta, P.C. 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 Dermatology Specialists of North Atlanta, P.C. Privacy Officer at 3655 Howell Ferry Rd. Suite 400 Duluth, GA 30096. With this consent, Dermatology Specialists of North Atlanta, P.C. 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, Dermatology Specialists of North Atlanta, P.C. 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. I have the right to request that Dermatology Specialists of North Atlanta, P.C. restricts 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 Dermatology Specialists of North Atlanta’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 consent, or later revoke it, Dermatology Specialists of North Atlanta, P.C. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date