

Commonwealth Dermatology, P.C.
Receipt of Privacy Practices Notice
And Consent For Use And Disclosure Of Protected Health Information

With my consent, Commonwealth Dermatology, P.C. may use and disclose my personal medical and financial information (protected health information) to carry out treatment, payment and healthcare operations. Please refer to Commonwealth 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. Commonwealth Dermatology 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 Commonwealth Dermatology's Privacy Officer at 7001 Forest Ave., #300, Richmond, VA 23230.

With my consent, Commonwealth Dermatology, P.C. may:

Call my home or other designated location and leave a detailed message on voice mail in reference to **appointment reminders, insurance or billing items**.

Call my home or other designated location and leave a detailed message on voice mail in reference to my **clinical care, including laboratory results**. Preferred phone no. for clinical messages _____

Commonwealth Dermatology, P. C. may also *mail* to my home or other designated location any items that assist the practice in carrying out its business, such as appointment reminder cards and patient statements.

I have the right to request that Commonwealth Dermatology, P.C. restrict how it uses or discloses my PHI to carry out its business. 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 acknowledging that I have been provided with a copy of Commonwealth Dermatology's Notice of Privacy Practices and consenting to Commonwealth Dermatology's use and disclosure of my personal medical and financial information to conduct business.

I may restrict the individuals or organizations to which my health care information is released. I may also or 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, Commonwealth Dermatology, P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian and Relationship To Patient (If Applicable)