Greenwood Dermatology
92 South Park Blvd
Greenwood, IN 46143
317 889-7546

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Greenwood Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Greenwood'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. Greenwood Dermatology 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 Greenwood Dermatology, 92 South Park Blvd, Greenwood IN 46143 Attn: Office Manager.

With this consent, Greenwood Dermatology may call my home or 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, Greenwood Dermatology may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, lab results, and patient statements.
With this consent, Greenwood Dermatology may e-mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

You may have the following right with respect to your PHI:
The right to request that Greenwood Dermatology 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. The right to reasonable request to receive confidential communication of PHI by alternative means or at alternative locations. The right to inspect and copy your PHI. The right to amend your PHI. The right to obtain a paper copy of this notice from us upon request. The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.
If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. You must submit your request in writing to the office manager.

Do you give our office permission to discuss your medical information with a family member or care giver:
_____Yes ____No Please list name:

Name:_____Relationship:_____

Name:_____Relationship_____

By signing this form, I am consenting to Greenwood Dermatology'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 Greenwood Dermatology may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Please print patient name.