HIGH TIDE DERMATOLOGY CENTER

Debra L. Bailey, M.D.

Patient Consent for Use and Disclosure of Protected Health Information for High Tide Dermatology Center

With my consent, High Tide Dermatology Center, may use and disclose **protected health information** (PHI) about me to carry out **treatment, payment** and **health care operations** (TPO). Please refer to the 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 the consent.

High Tide Dermatology Center reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **High Tide Dermatology Center** Privacy Officer at 2350 Vanderbilt Beach Road, Suite 301, Naples, FL 34109.

With my consent, **High Tide Dermatology Center** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists the practice in carrying out TOP, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, **High Tide Dermatology Center** 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.

I have the right to request that **High Tide Dermatology Center** restrict how it uses or discloses my PHI to carry out TOP. However, the practice is not required to agree to my requested restrictions. But if it does agree, it is bound by such agreement. By signing this form, I am consenting to **High Tide Dermatology Center** use and disclosure of my PHI and 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, **High Tide Dermatology Center** may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Patient's Name_____**Date** _____

Print name of Patient or Legal Guardian _____

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