

PERIMETER DERMATOLOGY, P.C.
5505 PEACHTREE DUNWOODY RD SUITE 412
ATLANTA, GA 30342
(404) 459-9177 FAX (404) 389-0400

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

With my consent, **Perimeter Dermatology, P.C.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Perimeter Dermatology P.C.**'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. **Perimeter Dermatology, P.C.** 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 **Perimeter Dermatology P.C.**'s Privacy Officer at [5505 Peachtree Dunwoody Rd, Suite 412, Atlanta, GA 30342].

Internet Delivery of PHI: The internet is **NOT** considered HIPAA compliant with regard to protecting your health information. If, under certain circumstances, you require **Perimeter Dermatology, P.C.** to transmit PHI via the internet you acknowledge by your signature that you understand the compromise the internet poses to the security of your PHI and hold **Perimeter Dermatology, P.C.** harmless against breach of confidentiality.

Patient's signature _____ **Date** _____

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, and patient statements as long as they are marked Personal and Confidential.

Perimeter Dermatology, 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 **Perimeter Dermatology P.C.**'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, **Perimeter Dermatology, P.C.** may decline to provide treatment to me.

Please Print Patient Name

Please list name of any other person we may give test results to.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian