HIPAA FORM

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Laing Dermatology & Skin Cancer Center, PA, may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Laing Dermatology & Skin Cancer Center, PA 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. Laing Dermatology & Skin Cancer Center, PA, 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 Laing Dermatology & Skin Cancer Center, PA, 6807 Knightdale Blvd., Suite C, Knightdale, NC 27545.

Laing Dermatology & Skin Cancer Center, PA, may call my home &/or cell phone and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. By signing this consent form, you are also giving Laing Dermatology & Skin Cancer Center, PA the right to discuss your visit in the presence of any person that accompanies you into the exam room.

Laing Dermatology & Skin Cancer Center, PA may mail to my home any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements and laboratory results.

Laing Dermatology & Skin Cancer Center, PA may e-mail to me at the email address listed on my registration form any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, and patient statements and relaying laboratory test results or other clinical information.

I have the right to request that Laing Dermatology & Skin Cancer Center, PA , restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. 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 Laing Dermatology & Skin Cancer Center, PA to use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

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 revoke my consent, Laing Dermatology & Skin Cancer Center, PA reserves the right to dismiss me from the practice after proper written notice is given. If I do not sign this consent, Laing Dermatology & Skin Cancer Center, PA, reserves the right to decline to accept me as a patient. This form is not alterable and any cross outs/ changes are not acceptable.

Signature of Patient or Legal Guardian_____

Patient's Name (printed) _____

Date signed_____

I authorize you to release information to the following persons in addition to myself:
(examples: spouse and/or caregiver)

Name: _____

Relationship to patient_____

Revised 9/23/13