



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Brian E. Dubow, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Brian E. Dubow, M.D.'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. Brian E. Dubow, M.D. 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 our office.

With my consent, Dr. Dubow Dermatology may call my home or other designated location, and leave a message on voicemail or in person, 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.

With my consent, Dr. Dubow Dermatology may send e-mail, either to my home or another 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 Dr. Dubow Dermatology to 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.

By signing this form, I am consenting to Brian E. Dubow, M.D.'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, Dr. Dubow Dermatology may decline to provide treatment to me.

I authorize Dr. Dubow and/or staff to contact me via the following:

Telephone: Mobile: _____ Other (specify): _____

Email Address: _____

Name of alternative person I elect to receive my PHI: _____

Telephone: Mobile: _____ Other (specify): _____

Signature: _____
(Patient or individual legally authorized to consent)

Date: _____

This authorization shall remain in effect until you are notified by me in writing of any changes.