Eastside Dermatology
& Skin Care Center
www.EastsideDermatology.com

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Eastside Dermatology & Skin Care Center may use and disclose protected health information (PHI) about me or my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Eastside Dermatology & Skin Care Center Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been provided the opportunity to, review the Notice of Privacy Practices prior to signing this consent. Eastside Dermatology & Skin Care Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised copy of our Notice of Privacy Practices may be obtained by forwarding a written request to the Eastside Dermatology & Skin Care Center Privacy Officer at 150 Taylor Station Road, Suite 250, Columbus, Ohio 43213.

With my consent, Eastside Dermatology & Skin Care 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 assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my
clinical care, including laboratory results and among others.

With my consent, Eastside Dermatology & Skin Care 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.

By signing this form, I am consenting to Eastside Dermatology & Skin Care Center'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, Eastside Dermatology & Skin Care Center may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

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Print Patient's Name

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Print Name of Legal Guardian