THE PRINCETON CENTER FOR DERMATOLOGY, LLC
ROBYN B. NOTTERMAN M.D.
KATHLEEN M. ROSSY M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Princeton Center For Dermatology, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Princeton Center For Dermatology, LLC 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. The Princeton Center For Dermatology 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 The Princeton Center For Dermatology Privacy Office at 800 Bunn Drive, Suite 201, Princeton, NJ 08540.

With my consent, The Princeton Center For Dermatology 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 among others.

With my consent, The Princeton Center For Dermatology 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.

With my consent, The Princeton Center For Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements. I have the right to request that the Princeton Center For Dermatology restrict how it uses or disclose 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 The Princeton Center For Dermatology's use and disclosure of 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, The Princeton Center For Dermatology may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_______________________________________ _________________________
Patient Name Date

I, _________________________, have read a copy of The Princeton Center For Dermatology's **Privacy Practices.**
Patient Name

_______________________________________ _________________________
Signature of Patient or Legal Guardian Date