Academic Dermatology Associates

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Academic Dermatology Associates may use and disclose **P**rotected **H**ealth **I**nformation (**PHI**) about me to carry out **T**reatment, **P**ayment and healthcare **O**perations (**TPO**). Please refer to Academic Dermatology Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures. In clinical trials, my information could be disclosed to the Sponsor, The Clinical Research Organization, The Food and Drug Administration, and the Institutional Review Board. In all instances my identity will be kept protected as much as possible.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Academic Dermatology Associates reserves the right to revise its Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Academic Dermatology Associates, 1203 Coal SE, Albuquerque, NM 87106.

With my consent, Academic Dermatology Associates 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, Academic Dermatology Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, newsletters, and patient statements

With my consent, Academic Dermatology Associates may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, newsletters, and patient statements. I have the right to request that Academic Dermatology Associates 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 Academic Dermatology Associates' 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, Academic Dermatology Associates may decline to provide treatment to me.

_____
Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Legal Guardian Relationship

Rev 10-20-09