



Patient Consent for Use and Disclosure of Protected Health Information

I HAVE BEEN OFFERED A COPY OF PRIVACY PRACTICES

With my consent, Coastal Dermatology/Dr Kimberly Soderberg may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Please refer to Coastal Dermatology’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. Coastal 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 Coastal Dermatology’s Privacy Officer at 3176 Holland Rd, Suite 103, Virginia Beach, VA 23453.

With my consent, Coastal Dermatology **may call my home or other designated location and leave a message on voice mail, in person or by e-mail** 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/biopsy results among others.

With my consent, Coastal Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointments reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Coastal Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If the practice agrees to the requested restrictions, it is bound by this agreement.

By signing this form, I am consenting to Coastal Dermatology’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, Coastal Dermatology may decline to provide treatment to me.

*Please check here to request that verbal information regarding diagnostic and/or recommendations for treatment is discussed directly with **you and you alone**.*

If you do choose to give permission for your PHI to be discussed with a spouse, family member, care giver, etc.; list them below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Date of Birth: _____

Email Address: _____

Signature: _____ Date: _____