The Dermatologic Surgery Center of Washington, LLC
Skin Cancer Treatment Center, LLC
5530 Wisconsin Ave., Suite# 820, Chevy Chase, MD 20815
Tel : (301) 652-8081 • Fax: (301)-652-8627

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it

Name: ____________________

Date of Birth: ____________________

Signature: ____________________

Date: ____________________

I would like to be contacted in the following manner (check all that apply):

Home Telephone: ____________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ OK to use fax# ____________________

Work Telephone: ____________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ OK to use fax# ____________________

Written Communication:

- ☐ OK to mail to my home address
- ☐ OK to mail to my mail address
- ☐ OK to use fax# ____________________

Cell Communication:

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

E-Mail Address: ____________________

Other: ____________________

With my consent; **The Dermatologic Surgery Center of Washington, LLC** and **Skin Cancer Treatment Center, LLC,** may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to their notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent; **The Dermatologic Surgery Center of Washington, LLC** and **Skin Cancer Treatment Center, LLC,** 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 reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. They can also mail to my home any items such as appointment reminder cards or recall cards and patient statements. The office can also email me any of this information to the email address I provided.

I have the right to request any restrictions to the uses and discloses of 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. I also have reviewed the notice of privacy practices prior to signing this consent. I am aware that **The Dermatologic Surgery Center of Washington, LLC** and **Skin Cancer Treatment Center, LLC,** reserves the right to revise its notice at anytime. An updated notice may be obtained by forwarding a written request to 5530 Wisconsin Ave., Suite 820, Chevy Chase, MD 20815.

By signing this form, I am consenting to **The Dermatologic Surgery Center of Washington, LLC** and **Skin Cancer Treatment Center, LLC,** to use and disclose 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 DON'T sign this consent, **The Dermatologic Surgery Center of Washington, LLC** and **Skin Cancer Treatment Center, LLC,** may decline to provide treatment to me.