

**LAS COLINAS DERMATOLOGY, P.A.**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, Las Colinas Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Las Colinas 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. Las Colinas 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 Las Colinas Dermatology Privacy Officer at 440 W. IH 635, Suite 365 Irving, TX 75063.

With my consent, Las Colinas 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. I understand that Las Colinas Dermatology may occasionally be offering special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas 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 , patient statements and/or information regarding special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas Dermatology 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 and patient statements. I have the right to request that Las Colinas 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, but if it does, it is bound by this agreement.

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

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian