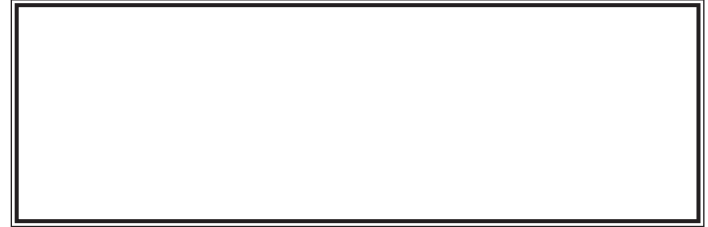
Ira L. Skolnik, M.D., Ph.D.
Steven Franks, M.D.



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

With my consent, Family Dermatology, p.c. may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Family Dermatology, p.c.'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. Family Dermatology, p.c. reserves the right to revise its *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to the Privacy Officer at 747 Main Street, suite 212, Concord, MA 01742.

With my consent, Family Dermatology, p.c. 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 my treatment plan and payments, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and biopsy results among other things.

With my consent, Family Dermatology, p.c. may mail to my home or other designated location any items that assist the practice in carrying out my treatment plan and payments, such as appointment reminder cards, patient statements, missed appointment letters, discharge letters, copies of my medical chart, and laboratory and biopsy results.

I have the right to request that Family Dermatology, p.c. restrict how it uses or discloses my personal health information to carry out my treatment plan. 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 Family Dermatology, p.c. use and disclosure of my personal health information to carry out my treatment plan and maintain my account in good standing.

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, Family Dermatology, p.c. may not decline to provide treatment to me.

Patient's Name	Date
Signature of Patient (or Legal Guardian)	Print name of person signing (if different from patient)

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