DANIEL SIEGEL, MD   ANTHONY WONG, MD   DARREN MOLLICK, MD

MOHS MICROGRAPHIC SURGERY ■ DERMATOLOGIC SURGERY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Long Island Skin Cancer & Dermatologic Surgery, PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Long Island Skin Cancer & Dermatologic Surgery, P.C. 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. Long Island Skin Cancer & Dermatologic Surgery, P.C. 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 Long Island Skin Cancer & Dermatologic Surgery, P.C.'s Privacy Officer.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, 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 TPO, such as appointment reminders, and insurance items and return calls requesting a call back.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Long Island Skin Cancer & Dermatologic Surgery, P.C. 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 Long Island Skin Cancer & Dermatologic Surgery, P.C. 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 Long Island Skin Cancer & Dermatologic Surgery, P.C.'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, Long Island Skin Cancer & Dermatologic Surgery, P.C. may decline to provide treatment to me.

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

Home Telephone: ( ) OK to leave message with detailed information
Work Telephone: ( ) OK to leave message with detailed information

List any family member we may release medical information to:

Name: ______________________________ Relationship: __________ Phone: __________

Name: ______________________________ Relationship: __________ Phone: __________

X____________________________ ____________________________ ________________
Patient's Signature Print patient's name Date

____________________________ ____________________________ ________________
Legal Guardian's Signature Print name of Legal Guardian Date

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