WORCESTER DERMATOLOGY ASSOCIATES, P.C.
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Worcester Dermatology Associates may use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Worcester Dermatology Associates' 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.
Worcester Dermatology Associates 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 the Privacy Officer at 100 Central Street, Worcester, MA 01608.

With my consent, Worcester Dermatology Associates 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 our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among other things.

With my consent, Worcester Dermatology Associates may 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 as long as they are marked Personal and Confidential.

I have the right to request that Worcester Dermatology Associates 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 Worcester Dermatology Associates 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, Worcester Dermatology Associates may not decline to provide treatment to me.

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Signature of Patient of Legal Guardian	Date
____________________________	_______________________________
Patient's Name	Print Name of Patient or Legal Guardian