PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, DOUGLAS Kligman, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Douglas Kligman, M.D.’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. Douglas Kligman, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by request to Douglas Kligman, M.D., Privacy Officer.

With my consent, Douglas Kligman, M.D. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent, Douglas Kligman, M.D. 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.

With my consent, Douglas Kligman, M.D. may email 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 Douglas Kligman, M.D. 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 Douglas Kligman, M.D.’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, Douglas Kligman, M.D. may decline to provide treatment to me.

PRINT NAME ____________________________________________________________________________________ DATE _________________________

SIGNATURE _____________________________________________________________________________________________________________________

PATIENT’S NAME (if other than self) ___________________________________________________________________________________________

RELATIONSHIP TO PATIENT (if other than self) ________________________________________________________________________________