SKIN & LASER CENTER OF NJ

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Definitions:

SLCNJ: Skin & Laser Center of NJ
PHI: Protected Health Information
TPO: Treatment Payment Options

With my consent, Skin & Laser Center of NJ may use and disclose Protected Health Information about me to carry out treatment, payment, and healthcare operations. _________ **Initials**

I have the right to review the Notice of Private Practices prior to signing this consent. Skin & Laser Center of NJ 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 Skin & Laser Center of NJ's Compliance Officer. _________ **Initials**

PLEASE INITIAL EACH ITEM THAT YOU WOULD ALLOW
With this consent Skin & Laser Center of NJ LLC (SLCNJ, LLC) may:

- Call my home or cellphone at ____________________________ /______________________________ and leave a message on the voicemail or speak to any such person that may answer the phone in reference to any items that assist its healthcare providers or employees in carrying out TPO such as appointment reminders, insurance items, and requests for a call back. _________ **Initials**

- Call me at the following phone number(s) ________________________ may leave a message in reference to items that assist the practice in carrying out TPO, such as appointment reminders and any calls pertaining to my clinical care schedule. However, at these numbers SLCNJ will NOT leave a message about my medical condition or lab results with any other person. _________ **Initials**

- SLCNJ has my permission to send and request faxes to/from other providers, regarding items that assist SLCNJ in carrying out TPO. _________ **Initials**

- Mail to my home (or other location designated in writing by me) information containing any items that may assist SLCNJ, LLC in carrying out TPO, such as appointment reminder cards and patient statements. _________ **Initials**

- Answer questions about my healthcare and billing with the following family members: ____________________________________

  ____ _________ **Initials**

I have the right to request that SLCNJ restrict how it uses or discloses my PHI to carry out TPO. However, under certain circumstances, SLCNJ would not be 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 SLCNJ use and disclosure of my PHI to carry out TPO.

I ____ **acknowledge that** I **have read and understand the above.**
(patient name)

X ____ Date: ___________________________
(Patient signature; if minor then parent/guardian must sign)

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, SLCNJ may decline to provide treatment to me. If you have any questions about our Notice of Privacy Practice, please contact the office at 201-500-7525.