Charles R. Sexton, M.D.

Dermatology

Patient Consent Form

Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for **Charles R. Sexton, M.D**. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Charles R. Sexton, M.D**. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practice prior to signing this consent. **Charles R. Sexton, M.D.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to **HIPAA Compliance Office at Charles R. Sexton, M.D., 15825 Laguna Canyon Road, Suite 203, Irvine, California 92618**.

With this consent, **Charles R. Sexton, M.D**. may call my home or work and leave a message on my voice mail or in person in reference to any items that assist 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.

I have the right to request that **Charles R. Sexton, M.D**. restricts how he uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Charles R. Sexton, M.D**. to use or disclose 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, or later revoke it, **Charles R. Sexton, M.D**. may decline to provide treatment to me.

Signed By: _____ _____

Signature of Patient Date

_____ _____

Patient's Print Name Relationship to Patient

_____

Print Name of Legal Guardian, if applicable