Dermatology & Skin Cancer Specialists (DSCS)
11550 Granada, Leawood, KS 66211
3265 NE Ralph Powell Rd., Lee's Summit, MO 64064
17053 S. 71 Hwy, Ste 204, Belton, MO 64012
9411 N. Oak Trafficway, Ste 230, Kansas City, MO 64155
2609 Glen Hendron Dr., Liberty, MO 64068

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, DSCS may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to DSCS'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. DSCS 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 DSCS's Privacy Officer at 11550 Granada, Leawood, KS 66211.

With my consent, DSCS 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, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, DSCS 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, DSCS may take photographs for my health record to assist the practice in carrying out TPO.

With my consent, DSCS 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.

Other than as listed above, my **PHI** may be discussed with the following: (please check all that apply)
☐ Spouse ☐ Child(ren) ☐ Parent(s) ☐ Medical Power of Attorney (must supply copy) ☐ Other

Please list: _____

My **billing** information may be discussed with the following: (please check all that apply)
☐ Spouse ☐ Child(ren) ☐ Parent(s) ☐Medical Power of Attorney (must supply copy) ☐ Other

Please list: _____

I have the right to request that DSCS 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 DSCS'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, DSCS may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____
Patient's Name Date