Allen A. Flood, M.D.
BOARD CERTIFIED
DERMATOLOGY
DISEASES OF THE SKIN, HAIR AND NAILS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ALLEN A. FLOOD MD may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to ALLEN A. FLOOD MD'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. ALLEN A. FLOOD MD reserves the right to revise its Notice of Privacy Practices at anytime. A Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 650 Pennsylvania Avenue, SE, Suite 420, Washington, DC 20003.

With my consent, ALLEN A. FLOOD MD 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, ALLEN A. FLOOD MD 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/or Confidential.

With my consent, ALLEN A. FLOOD MD 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 ALLEN A. FLOOD MD 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 ALLEN A. FLOOD MD'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, ALLEN A. FLOOD MD may decline to provide treatment to me.

_____ _____

Patient's Date

_____ _____

Signature of Patient or Legal Guardian Print Name of Person Signing

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