

# **Skin Care Center of Southern Illinois L.L.C.**

## **Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Skin Care Center of Southern Illinois (SCC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to SCC'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. SCC 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 SCC at 4107 South Water Tower Place, Mt. Vernon, Illinois 62864.

With my consent, SCC may call my home or other designated location and leave a message on voice mail, answering machine, 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, SCC 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, SCC may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that SCC 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 Skin Care Center's (SCC) use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (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, SCC may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patient's Name (Please Print)

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Date