Camilla **McCalmont**, MD
Jennifer **Fu**, MD

A medical dermatology practice

CONSENT FOR USE OF PROTECTED HEALTH INFORMATION

With my consent, Camilla McCalmont, MD, Inc. may use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations. All PHI will be protected as per applicable law.

With my consent, Camilla McCalmont, MD, Inc. may mail my home or other designated locations any items that assist in treatment, payment, and health care operations, including appointment reminders, insurance information, laboratory and pathology results, etc. I will indicate if I desire mail to be marked Personal and Confidential.

With my consent, if I have provided an email address, the physicians and staff of Camilla McCalmont, MD, Inc. may email me information that will assist in operations, specifically appointment reminders. Rather than emailing questions to my provider, I understand that the patient portal or a telephone call should be used for sending messages regarding confidential medical information.

By signing this form, I consent to Camilla McCalmont MD, Inc. using my PHI as needed to carry out treatment, payment, and health care operations. I may revoke this consent in writing except to the extent that Camilla McCalmont, MD, Inc. has already utilized PHI in reliance upon my prior consent. If I do not sign this form, the physicians of Camilla McCalmont, MD, Inc. may be unable to provide treatment.

_____

Signature of patient or legal guardian

_____

Printed Name Date

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