

**Inland Dermatology Skin Care Center
Keith M. Gross, MD**

Patient Consent for Use and Disclosure or Protected Health Information

Patient Name: _____ **Date of Birth:** __ / ____ / ____

With my consent, Keith M. Gross, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Please refer to Keith M. Gross, M.D.'s Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Keith M. Gross, M.D. 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 Keith M. Gross, M.D., Privacy Officer, 12550 Hesperia Rd, #218, Victorville, CA 92395.

With my consent, Keith M. Gross, M.D. 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, Keith M. Gross, M.D. 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, Keith M. Gross, M.D. may email to my home to other designated email address 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 Keith M. Gross, M.D. 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, my signing this form, I am consenting to Keith M. Gross, M.D. 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, Keith M. Gross, M.D. may decline to provide treatment to me.

Patient/Guardian Signature

Date

Patient's Name