

**PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

This consent authorizes Michael A. Tomeo, M.D. & Associates/Advanced Dermatology Center to use and disclose my health information for treatment, payment and health care operations.

**EXPLANATION OF RIGHTS**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Michael A. Tomeo, M.D. & Associates/Advanced Dermatology Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact you to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**CURRENT CONTACT INFORMATION FOR OUR PRIVACY OFFICER**

Practice Name: Michael A. Tomeo, M.D. & Associates/Advanced Dermatology Center  
Attention: Privacy Officer – Office Manager  
Address: 1650 Huntingdon Pike, Suite 354, Meadowbrook, PA 19046  
Telephone: 215-938-8771 FAX: 215-938-1121

**CONSENT**

I have read and understand the above Explanation of Rights prior to signing this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_