Integrated Dermatology of Mission Viejo, APMC
26691 Plaza, Ste 230, Mission Viejo, CA 92691-6300
Tel 949-364-2904
Fax 949-364-2909

Consent for Use and Disclosure of Protected Health Information

I grant permission to providers and staffs at the Integrated Dermatology of Mission Viejo, APMC (IDMV) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures.

I understand that I have the right to review the NPP prior to signing this consent. Dr. Frank Zhan reserves the right to revise the NPP at any time. A current version of NPP can be obtained by submitting a written request to our Privacy Officer at 26691Plaza, Suite 230, Mission Viejo, CA 92691.

I understand and give consent to IDMV to call and text 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 billings, and any call pertaining to my clinical care, including but not limited to laboratory results.

I understand and give consent to IDMV to email or mail 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.

I understand that I have the right to request IDMV to restrict how it uses or discloses my PHI to carry out TPO. However, this practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing below, I acknowledge that I understand that I am consenting to IDMV's use and disclosure of my PHI to carry out TPO.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, providers at IDMV may decline to evaluate and treat me.

Patient Signature _____ Date _____
or Guardian/Legal representative for patient *m/d/yyyy*

Patient or Legal Guardian Name Printed _____