Knight Dermatology Institute

The Center for Cosmetic and Laser Skin Surgery
J. Matthew Knight, M.D.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Knight Dermatology Institute may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Knight Dermatology Institute 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.

Knight Dermatology Institute 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 the Knight Dermatology Institute Privacy Officer at: 801 N. Orange Avenue, Suite 520, Orlando, FL 32801.

With my consent, Knight Dermatology Institute may call my home or other designated location and leave a message on my voicemail 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, etc.

With my consent, Knight Dermatology Institute 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, Knight Dermatology Institute may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and laboratory results. I have the right to request that Knight Dermatology Institute restrict how it uses or discloses my PHI to carry out TPO. 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 Knight Dermatology Institute 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, Knight Dermatology Institute may decline to provide treatment to me.

Signature of Patient or Legal Guardian: ____

Patient's Printed Name: ____

Date: ____