

# Beer Dermatology

Kenneth R. Beer MD, FAAD  
Hillary Julius, PA-C  
Kerry Fike, MD

## Patient Consent For Use and Disclosure of Protected Health Information (PHI)

With my consent, Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD Notice of Privacy Practices for a more complete description of such uses and disclosures.

Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD at  
1500 N. Dixie Highway Suite 305 West Palm Beach, FL 33401.

With my consent, Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh 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, Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh 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, Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh may e-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. I have the right to request that Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh 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.

By signing this form, I am acknowledging receipt of Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh Notice of Privacy Practices.

By signing this form, I am consenting to Beer Dermatology; Kenneth R. Beer MD, FAAD; Hillary Julius PA-C; Kerry Fike, MD, RPh's use and disclosure of my PHI to carry out TPO.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

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Print Name of Patient or Legal Guardian

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### For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and consent to use and disclose PHI to carry out TPO, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communication barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify) \_\_\_\_\_
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