KAY AESTHETIC DERMATOLOGY
Martin H. Kay, M.D.
201 S. Buena Vista St. Suite 420
Burbank, California 91505
Telephone: (818) 238-2350
Fax: (818) 238-2351

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY STANDARDS AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Martin H. Kay, M.D. and associates, may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Dr. Martin H. Kay's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have had the opportunity to review the Notice of Privacy Practices prior to signing this consent. Martin H. Kay, M.D. 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 Martin H. Kay, M.D. at 201 S. Buena Vista St. Suite 420, Burbank, CA 91505.

With my consent Martin H. Kay, M.D. and associates may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out the Treatment, Payment and Healthcare Operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Martin H. Kay, M.D. and associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as reminder cards and patient statements as long as they are marked Personal and Confidential.

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 consenting to Dr. Martin H. Kay's use and disclosure of my Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO).

I have revoked my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Martin H. Kay, M.D. may decline to provide treatment to me.

______________________________________ ______________
Signature of Patient or Legal Guardian Date

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Print Patient's Name

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Print Name of Legal Guardian