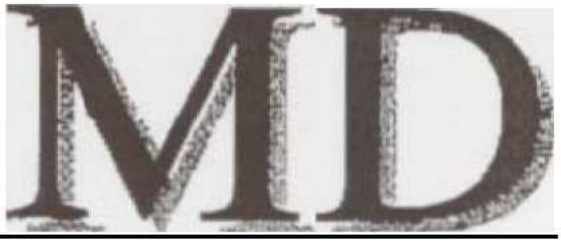

mecklenburg dermatology associates

Welcome New Patient!

Attached you will find your new patient packet of forms. It is very Important that you take time to READ THEM, FILL THEM OUT, AND SIGN EACH FORM BEFORE YOUR APPOINTMENT! This will save time at the check in desk when you arrive. Please remember to bring your current insurance card with you because we will need to make a copy of your card at each office visit. If your insurance requires a co-pay or deductible, please be prepared to pay at the time of service, as we do not bill our patients for this. Please arrive 10-15 minutes before your appointment to register at the front desk.

Be sure to bring all forms with you to your appointment. Please do not mail these forms back to our office, as we may not receive them in the office in time for your appointment! All minors must have parent or legal guardian present for their initial office visit.

Our current address is:

Randolph Medical Center Building
1928 Randolph Road
Suite #316
Charlotte, NC 28207

We are located next to the Midtown Medical Plaza (formerly the Nalle Clinic building) and the Metroview buildings on Randolph Rd. Should you need directions to our facility, please call our office ahead of time or visit our website at www.meckderm.com and click on "Contact Us" to obtain specific directions to our office.

We look forward to serving you soon!

Thank you,

Mecklenburg Dermatology Associates, PA

PATIENT HISTORY

Patient _____ Date _____

Primary Care Physician _____

Did he/she refer you? YES/NO

Are you allergic to any medications? YES/NO If so, please list below:

_____ _____ _____

_____ _____ _____

List all Medications that you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you now have or have you ever had: (mark if yes)

___High Blood Pressure

___Artificial joints

___Heart disease

___Asthma/hay fever

___Diabetes (sugar)

___Pacemaker

___Take Coumadin or Aspirin daily (circle which one)

___Other _____

Skin:

When exposed to sun do you: Tan Only Burn then tan Burn only

Have you ever had skin cancer? YES/NO If so, what kind?_____

Has anyone in your family had skin cancer? YES/NO If so, what kind?_____

Do you have a history of any specific skin diseases? YES/NO

If yes, please list _____

Does anyone in your family have a history of skin problems? YES/NO

If yes, please describe _____

Completed by: Patient/Medical Assistant _____(please initial)

Reviewed by: _____

(provider signature/date)

Mecklenburg Dermatology Associates, PA
PATIENT INFORMATION AND AUTHORIZATION
Please complete all information below

Patient's Name_____
First Middle Last Nickname

Patient's Address _____ _____

City_____ State_____Zip_____

Patient's Soc. Security #_____ _____

Male_____ Female_____

Patient's Date of Birth _____

Patient's Home #_____

Patient's Work #_____

Patient's Employer_____

Responsible Party's Name_____
First Middle Last

Responsible Party's Address _____ _____

City_____ State_____Zip_____

Resp. Party's Home# _____ Resp. Party's Work# _____

Insured's Soc. Security #_____ Insured's Date of Birth_____
(Both the insured's SS# and date of birth are required when filing your insurance claim)

Insured's Employer _____

Name (Different from Resp. Party) in Case of Emergency _____

Emergency Contact Phone# & Relationship to Patient _____

If referred to our office by another physician, which physician referred you? _____

I request that payment of authorized medical insurance benefits (Medicare) be made to either me or on my behalf to the above named provider for any services furnished me by the provider. I authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits or the benefits payable to related services.

Patient/Guarantor Signature_____ Date _____

SINCE CHANGES ARE FREQUENT, PLEASE PROVIDE YOUR INSURANCE CARD(S) (IF APPLICABLE) FOR COPYING ON EACH VISIT

Mecklenburg Dermatology Associates, P.A.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, Mecklenburg Dermatology Associates, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mecklenburg Dermatology Associates' 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. Mecklenburg Dermatology Associates, P.A. 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 Mecklenburg Dermatology Associates Privacy Officer at 1928 Randolph Rd. Ste. 316, Charlotte, NC 28207.

With my consent, Mecklenburg Dermatology Associates, P.A. 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, Mecklenburg Dermatology Associates, P.A. 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, Mecklenburg Dermatology Associates, P.A. 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 Mecklenburg Dermatology Associates. P.A. restricts 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 consenting to Mecklenburg Dermatology Associates' 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, Mecklenburg Dermatology Associates may decline to provide treatment to me.**

Print Name of Patient or Legal Guardian _____

Signature of Patient or Legal Guardian _____

Date_____

Mecklenburg Dermatology Associates, PA
Consent to Treatment

I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as my physician or others at Mecklenburg Dermatology Associates consider to be necessary. I understand that:

I have the right to consent or to refuse consent, to any proposed procedure or therapeutic course.

Procedures performed may include one or more of the following: biopsy (either by shave or punch), cryotherapy (freezing), excision of lesions (by shave, snip, or wide excision), scraping of skin for viewing under the microscope, intralesional injection, or incision or drainage. There are risks to these procedures and they may include any and all but not limited to the following: pain, blistering, redness, burning, bleeding, infection, changes in the color/tone of the skin (lighter or darker), allergic reactions and/or scarring. Scars may be thick or depressed and occasionally may be painful or itch. Most of these side effects are temporary, but some, such as scarring, may be permanent.

Depending on the procedure, there may be risk of regrowth of the lesion. In addition, there may be need for additional treatment in the future. My doctor/physician assistant will discuss this with me

I am giving Mecklenburg Dermatology Associates the right to dispose of any tissue samples taken in a manner that is deemed necessary. This includes sending it for evaluation by a pathologist.

By signing this form, I am acknowledging that I have read, understand and agree to all of the above and give my consent for treatment.

Patient/Guardian Signature _____Date_____

Witness Signature _____Date_____

Insurance and Medical Records Release

Authorization for Release of Medical Information: Mecklenburg Dermatology Associates, PA and/or my physician(s) are authorized to furnish any medical information relating to my treatment to my insurance company, health maintenance organization, preferred provider organization, alternative delivery system, governmental or charitable agencies and their agents, my employer, and profession review organizations with whom I may have coverage or who may be assisting in payment or evaluation of my medical care for the purpose of collecting payment therefrom. I acknowledge and agree that Mecklenburg Dermatology Associates and/or my physician may, during the course of my treatment, grant access to students or faculty members in healthcare education programs to my medical records, observe or participate in my treatment or utilize data obtained from my medical records as authorized by Mecklenburg Dermatology Associates. I also authorize Mecklenburg Dermatology Associates an/or my physician to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. I understand that this authorization will not expire, but I may revoke this authorization, in writing and witnessed, at any time, except to the extent that action has already been taken in reliance on this authorization prior to its revocation.

Authorization to Release Medicare and Medicaid Information: I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act are correct. I understand that health care services paid for under Medicare and Medicaid are subject to review by professional review organizations, which may recommend denial of payment if my medical condition does no warrant continued care. I hereby authorize those agencies responsible for determining eligibility under these programs to provide to Mecklenburg Dermatology Associates and/or my physicians any information relating to the determination of my eligibility. I authorize Mecklenburg Dermatology Associates to submit a claim to Medicare for payment. I request that payment of any bills for services furnished under the Medicare program be made to either me or Mecklenburg Dermatology Associates, as the individual claim form and Mecklenburg Dermatology Associates may direct.

Advance Billing Notice Waiver of Liability: Your physician, after history and physical examination, may recommend or advise certain tests and/or studies which Medicare, Medicaid, or other third party payors may determine to be medically unnecessary, (for Medicare as defined under Section 1862 (a) 1 of the Social Security Act). If your physician or other health care professional of Mecklenburg Dermatology Associates have reason to believe that Medicare, Medicaid or other third party payor may deny coverage, you will be so informed and requested to sign an Advance Billing Notice or Waiver or Liability acknowledging that you have been informed of such information and are agreeing to pay Mecklenburg Dermatology Associates for these services if Medicare, Medicaid, or other third party payor deny benefit payment.

Your physician will only recommend and/or advise studies and/or tests which he/she deems to be in your best interest.

Medicare Lifetime Beneficiary Authorization (Applies to Medicare Patients Only): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Mecklenburg Dermatology Associates, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or benefits for related services.

Authorization to File Insurance Automatically: I hereby request and authorize Mecklenburg Dermatology Associates to file claims automatically after services have been rendered me. Individual requests will not be made. I will advise in writing Mecklenburg Dermatology Associates any alteration in this request or authority.

Payment: I agree to pay all charges for medical care rendered by Mecklenburg Dermatology Associates and its physicians to me. I guarantee the full and complete payment of all charges for medical care rendered by

Mecklenburg Dermatology Associates and its physicians. This is a guaranty of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. If I fail to pay for such charged due to Mecklenburg Dermatology Associates and it becomes necessary for Mecklenburg Dermatology Associates to institute collection efforts against me, I agree to pay Mecklenburg Dermatology Associates all costs of collection thereof, including reasonable attorney's fees incurred in connection therewith. I further agree that this authorization provides consent for Mecklenburg Dermatology Associates to release and obtain credit information from the area Credit Bureau and Collection Agency.

Assignment of Insurance Benefits (Not Including Medicare): I hereby authorize payment directly to Mecklenburg Dermatology Associates of medical or surgical benefits otherwise payable to me, including major medical insurance (but not including Medicare). I understand that I am financially responsible to Mecklenburg Dermatology Associates for its services in connection with treatment rendered during encounters, any such excess amount may first be applied to payment of any other indebtedness due by me or my legal dependents for other treatment rendered and the balance, if any remains, shall be paid to me.

Personal Property: Mecklenburg Dermatology Associates is not responsible for personal property worn or carried into the office. Every precaution will be taken to assure no loss; however, patients are urged not to wear jewelry which may need to be removed for examination, diagnostic testing, or treatment.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PROVISIONS PERTAINING TO MY RELATIONSHIP WITH MECKLENBURG DERMATOLOGY ASSOCIATES, P.A.

_____ _____

Date Patient or Parent, (if minor)

_____ _____

Date Guarantor Signature (if applicable)

_____ _____

Date Witness

WAIVER OF LIABILITY
Patients requiring insurance referrals

You have presented to Mecklenburg Dermatology Associates for evaluation and treatment. In order for the charges for this visit to be paid, your insurance requires that you have a referral in place from your primary care physician. Every effort has been made to secure this referral. However, it has been our experience that even with a referral in hand, insurance companies often refuse to pay for patient visits. Therefore, we are asking that you sign this waiver, agreeing to be financially *responsible for any* charges that your insurance refuses to cover.

If payment is denied by my insurance carrier, I will be held responsible for any and all charges incurred.

By signing below, I agree to be personally and fully responsible for payment to Mecklenburg Dermatology Associates.

Patient Signature_____ Date _____

Witness_____ Date _____

MECKLENBURG DERMATOLOGY ASSOCIATES, P.A.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name

_____

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Mecklenburg Dermatology Associates, P.A.

Signature _____ Date_____

OR

I have been notified of the Notice of Privacy Practices statement of Mecklenburg Dermatology Associates, P.A. and refuse a copy of said statement

Signature_____ Date_____

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003

Mecklenburg Dermatology Associates, PA

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

MECKLENBURG DERMATOLOGY OFFICE MANAGER, 1928 RANDOLPH RD., STE. 316

CHARLOTTE, NC 28207

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL
6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety

of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To

obtain a paper copy of this notice, contact **Mecklenburg Dermatology Office Manager at (704) 344-8846**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Mecklenburg Dermatology Office Manager, 1928 Randolph Rd., Ste. 316, Charlotte, NC 28207**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Mecklenburg Dermatology Office Manager at (704) 344-8846**.