Print Form

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following and complete the information requested.

Patient Name: _____Date of Birth:_____ Phone: _____

☐ yes ☐ no I give permission to discuss my dental care with immediate family members.

☐ yes ☐ no I give permission to discuss my dental care with_____ (grandparents, care-givers, etc).

☐ yes ☐ no I give permission to leave messages on answering machines

☐ yes ☐ no I give permission to call me at work regarding a change in an appointment

☐ yes ☐ no I give permission to call me at work to discuss my dental care

You must notify the receptionist if you answer NO to any of the above.

Signature _____ Date _____
Personal Representative/Parent(if applicable) _____ Relationship: _____

This consent is a condition of your treatment by us. If you refuse to sign consent, we may decline treatment.

I have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

We may use our professional judgment and experience to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up records, X-rays, or other similar forms of protected health information. I authorize my insurance benefits to be paid directly to Dental Park, realizing I am responsible to pay deductibles, co-payments, and non covered services. This consent is effective until revoked by you.

Privacy Practices Notice: A copy of our dental office's Notice of Privacy Practices is available upon request. It provides a description of our treatment, payment activities, and health care operations, uses and disclosures of your protected health information. This authorization excludes those entities that do not require written consent; including, but not limited to, insurance carriers, workers compensation, and treatment activities between one healthcare provider and another. By signing this form, you or those involved in your care or payment for that care, consent to our use of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining acknowledge
☐ Emergency situation prevented obtaining acknowledgement
☐ Other (please specify