Patient Consent for Use and Disclosure of Health Information

Patient Name: _____
Address: _____ City/State: _____ ZIP: _____
Telephone: _____ E-mail: _____

HIPPA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for you care.

With this consent, **Kyrene Family Dentistry** may call my home or other alternative location and leave a message on 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Kyrene Family Dentistry** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, **Kyrene Family Dentistry** may e-mail to my home or other alternative 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 Kyrene Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required restrictions, but if it does, it is bound by this agreement.

By signing this consent form you will have acknowledged that you have read our Notice of Privacy Practices.

You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to you revocation will not be affected. We may choose to discontinue you treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I _____ (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.
Signature: asdasd_____ Date:_____
Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

To whom are we authorized to disclose your personal information regarding dental treatment and financial obligations?

Please state the names of the individuals, including the relationship to the patient.

Name	Relationship	Name	Relationship
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Signature:_____ Date:_____

This document is not a substitution for legal device.