FAMILY DENTISTREE OF SARASOTA, INC.

CONSENT & ACKNOWLEDGEMENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT/ACKNOWLEDGEMENT

Name: _____

E-mail: _____ Patient: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: We may disclose your protected health information to carry out treatment (communication with other health professionals, to obtain payment, and/or for regular health operations) by signing this form; you will consent and acknowledge our use and disclosure of your protected health information.

Notice of privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time. Privacy Officer: Michelle Shultz

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship _____

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

FAMILY DENTISTREE OF SARASOTA, INC.

Keeping Your Personal Health Information Private

_____

(Last Name) (First Name) (M.I.)

Do we have your permission to:

Send an appointment reminder card to your home? Y____N____

Leave the following information on your home or cellular answering machine/voice mail:

Appointment information Y_____N_____ Billing Information Y_____N_____
Medical Information Y_____N_____

Leave medical information on your work answering machine/voice mail:

Appointment information Y_____N_____ Billing Information Y_____N_____
Medical Information Y_____N_____

I agree that the dental practice may communicate with me electronically at this email address: _____

(I am aware that there is some level of risk that third parties might be able to read unencrypted emails.)

I give permission to share appointment and/or billing information with the person named below:

Name: _____

I give permission to share medical information with the person named below:

Name: _____

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____