Dental Health Clinic

Ways in which we may use or disclose your health care information include, but are not limited to:

- To another provider or facility for the purpose of diagnosis, assessment or your treatment
- Another party, such as an insurance carrier for the purpose of receiving payment for services
- The use of that information within our practice for quality control of other operational purposes
- Business associates with whom we contract to perform and bill for a service for your benefit
- The use of that information to contact you by telephone, mail or email, with appointment reminders, information about our facility, or other health related information that may be of interest to you.

Along with this consent form, you may request a copy of our privacy practices. You have the right to read it before signing this consent. We reserve the right to change our privacy practices as described in that notice. The current notice is posted in our waiting room.

Your Right to Limit Uses or Disclosure: You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. Let us know in writing of any restrictions you wish to have. We are not required to agree with your restrictions; however, if we do agree, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke your consent at any time, in writing, except to the extent that our office has already disclosed your information. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your information if they contest any claims.

You have the right to refuse to sign this consent, but without it we are unable to submit claims to insurance. This in no way impacts your treatment except that you will be responsible for payment to our office. We also will be unable to refer you to another provider for treatment.

I have been offered a copy of this office's Notice of Privacy Practices. Initial: _____

By signing below, I give consent to disclose my personal health information.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)