Patient Consent Form

FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

- **Treatment**—We may disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.
- **Payment**—We may disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, your collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
- **Healthcare Operations**—We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment, improvement activities, conducting training program, and licensing activities.
- **Oral Photographs**—We may take oral photographs if needed. The photographs may be used for insurance purposes / documentation in our files.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy of our notice is available upon request.

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 Practice, 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 by contacting the Privacy Officer at our office.

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

Signature: I have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

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Patient Name Date

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Parent or Legal Guardian Date

11/2015