Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Redbank Family Dentistry to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(Please initial each item

_____ I have the right to review the Notice of Privacy Practices prior to signing this consent. Redbank Family Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to P.O box 158 Goose Creek, SC 29445.

_____ With this consent, Redbank Family Dentistry may call my home or other alternative location and leave a message on voice mail 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, Redbank 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 as long as they are marked "Personal and Confidential."

_____ With this consent, Redbank 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 Redbank Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ By signing this form, I am consenting to allow Redbank Family Dentistry to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Redbank Family Dentistry may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name