Silas E. Daniel, D.D.S.

Patient consent to the use and disclosure of health information
For treatment, payment or healthcare operations, per HIPAA regulations

I understand that as part of my dental healthcare, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff,

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the "Notice" prior to acknowledging this consent
- The right to restrict or revoke the use of disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

PLEASE PRINT

Restrictions:
**** I request the following restrictions to the use or disclosure of my health information:**

____

**** Please tell us with whom we may discuss your protected health information:**
(Example: spouse (name), children (name) s, other relatives (names), friends or caregivers (names)

____

**** Messages or Appointment reminders**
May we leave a message at your **home** using the doctor's/practice name: Yes ( ) No ( )
May we leave a message at your **work** using the doctor's/practice names: Yes ( ) No ( )

Messages will be of a non-sensitive nature, such as, appointment reminders.

I understand that as part of treatment, payment or healthcare operations, it may be necessary to disclosure health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

** I fully understand and accept / decline (please circle one) the information to this consent.
Signature___________________________________ Date_______________
Patient/Guardian
If other than the patient (Patient Name)____________________ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations?
Yes ( ) No ( )

For office use only
( ) Consent form received and reviewed by __________________ on __________.
( ) Consent form signature refused by patient
( ) Patient unable to sign consent form, Reason:___________________________