HORSEHEADS DENTAL

Helping People Help Themselves
Through Prevention and Education

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CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's name_____Date of birth_____

SS#_____

Dentist: Warren E. Eng, D.D.S., F.A.G.D.

My personal health information is private and confidential. I understand that my dentist and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my dentist and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information. I understand that sometimes the law may require the release of this information without my permission.

I can ask my dentist to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my dentist does not have to agree to my request. If my dentist does agree to my request, I understand that my dentist and his staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

> Writing, signing and dating a letter to my dentist revoking permission to disclose health information. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my dentist and his staff do not have to provide any further health care services to me.

My dentist has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the document before signing this agreement. If I ask, my dentist or his staff will provide me with the most current Notice of Privacy Practices, which also is posted at my dentist's office.

My signature below indicates that I have been given the opportunity to review a current copy of my dentist's Notice of Privacy Practices. My signature means that I agree to allow my dentist to use and disclose my personal health information to carry out treatment, payment and health care operations.

_____ _____

Patient's or legally authorized individual's signature Date

_____

Relationship to patient