

Bonham Family Dentistry

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Bonham Family Dentistry to use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO) as outlined by HIPAA Law. The Notice of Privacy Practices describes these disclosures more completely.

I have been provided with the Notice of Privacy Practices. This consent acknowledges my receipt of that Notice. I understand that I have the right to review it prior to signing this consent. I understand that Bonham Family Dentistry reserves the right to revise its' Notice of Privacy Practices at any time. I can receive a revised notice of Privacy Practices by written request at any time. Treatment will not be based on whether or not I sign this consent.

With this consent, Bonham Family Dentistry may contact me in reference to any items that assist the practice in carrying out TPO, including appointment reminders, insurance items, and any calls pertaining to my clinical care, including test results and follow-up calls, among others.

Additionally, I wish to allow the following people access to my PHI for purposes of communication regarding my treatment or payment for services. Such communications may include appointment reminders, insurance items, and calls regarding my clinical care, including results, instructions, among others. I may revoke this consent in writing, except to the extent that the practice has already made disclosure in reliance upon my prior consent. Bonham Family Dentistry may share my PHI with:

NAME:	RELATIONSHIP:	PHONE:

I DO NOT wish the following people to have access to my information without my express written consent.

NAME:	RELATIONSHIP:

Signed by: _____

Date: _____

Printed Name: _____

Relationship: SELF OTHER(_____))

CIRCLE ONE