Imperial Dental

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Consent Purposes for Dental Treatment and Payment

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my dental treatment or to conduct dental treatment. I understand that diagnosis or treatment of me maybe conditioned upon my consent, as evidenced by my signature on this document.

I understand I have the right to request restriction to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restrictions that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above organizations Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, **payment of my bills or in the performance of health care operations of the above organization**. The Notice of Privacy Practices are also provided at the above organization and on the website if applicable. This Notice of Privacy Practices also describes my rights and the above named organization's duties with respect to my protected health information.

The above named organization reserves the right to update the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking of any changes and a copy of one at the time of my next appointment.

Date_____
Patient or Personal Representative (print) _____

Patient or Representative Signature _____

_____
Description of Personal Representative's Authority

Yearly update

Date/Signature_____

Date/Signature_____

Date/Signature_____