Consent for Use/Disclosure of Personal Health Information and Receipt of Notice of Privacy Polices

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities. Your PHI consists of name, full address, telephone #'s, and Social Security #.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI. For questions concerning our Notice of Privacy Policies, please contact: Diane Coombs, Office Manager. You may reach her at 317-898-9231.

Patient Name: ____ Acct#________

I, ______________________________________, have received a copy of German Church Rd. Family Dentistry, Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Signature:____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name & Relationship:____

HIPAA RELEASE OF INFORMATION

Information about my health and well being may be released to:

1. **Anyone or the following only____**
2. **I may be contacted by mail confirming my dental appts.: Yes or No**
3. **Messages may be left w) someone, on voicemail or answering machine: Yes or No**

The following information may be released unless otherwise restricted:

Appointment date and time; Prescription directions;
Procedures/ Referrals; and Insurance Information

Any Restrictions to the above:____

You may contact the subscribers employer concerning insurance denials and additional information for filing a dental/ medical claim: Yes or No

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Date **Signed**