



CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name: _____ Date: _____

Uses & Disclosures

I authorize the use and disclosure of my Personal Health Information by the dental practice of Maxwell Thaney, DDS, 64 North Main Street, Brockport, NY 14420 (heretofore referred to as the Dental Practice) and by the dental practice's workforce members, health care professionals and vendors providing services or supplies to me for purpose of treatment, payment and health care operations.

Important Information Regarding Consent

- I. I understand state laws require my consent before the Dental Practice may use or disclose my Personal Protected Health Information for treatment, payment or health care operations.
- II. I understand that the information may be used or disclosed by the Dental Practice to:
 - a. Diagnose, plan or provide for my care and treatment;
 - b. Communicate among various health care professionals who are involved in my care or treatment;
 - c. Obtain payment for care provided by the Dental Practice or for the payment activities of another health care provider or entity;
 - d. Provide information to my dental insurance company or plan;
 - e. Obtain payment from my dental insurance company or plan;
 - f. Assess and review the quality of my care; and
 - g. Conduct its business and health care operations.
- III. I understand that my signature on this Consent is required in order for me to receive care from the Dental Practice and that the Dental Practice may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.
- IV. I understand that further information on the Dental Practice's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Dental Practice's Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices from Maxwell Thaney, DDS, and have been advised of how the Dental Practice (or other named individuals and organizations listed in the Notice) will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices that describe how the Dental Practice will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and generic and psychotherapy notes. I have read and understand the terms of this Consent. I have had an opportunity to ask questions about use or disclosure of my protected Health Information.

Signature of Patient or Personal Representative _____
Date

Description of Personal Representative's Authority _____
Address of Personal Representative

Daytime Phone: _____ Evening Phone: _____

Internal Use Only
Name/Title of Person Obtaining Consent: _____ Date: _____