CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR DENTAL CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually Protected Health Information (""PHI") by Dr. Carol Schaffer's Dental Office (Office) in order to carry out treatment, payment,or dental care operations. The Patient has a right to review the Office's Notice of Privacy Practives for PHI, (which are posted in the Office, or can be obtained by mail) for a complete description of the potential uses and disclosures of such information, prior to signing this consent form.

Patient retains the right to request that the Office further restrict how his/her PHI is used or disclosed to carry out treatment, payment, or dental care operations. The Office is not required to agree to such requested restrictions; however, if the Office does agree to Patient's requested restriction(s), such restrictions are then binding on the Office.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Office in writing. The revocation shall be effective *except* to the extent that the Office has already taken action in reliance on the Consent. If Consent is revoked by Patient, he/she must submit written request to Office Privacy Contact, namely Business Office Manager.

The Office may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Office is required by law to treat individuals.) If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Office has the right to refuse to provide further treatment to Patient as of the time of revocation.

I HAVE HAD OPPORTUNITY TO READ THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS, AND TO THOSE CHECKED BELOW:

(Please Circle)

YES / NO I give consent to this Office to use my work number to call to confirm my appointments

YES / NO When receiving confirmation calls, I give my consent to this Office to leave a message on a machine or with whomever answers the phone.

YES / NO When receiving written correspondence from this office, I give consent to use the most recent address on file with this Office. If no, (please list address you would like to receive correspondence at_____
_____

Please list the name of the person/person's with whom you give consent for the Office to discuss my dental treatment. 1._____ 3._____
2._____ 4._____

DATE:_____ SIGNATURE:_____

Signature of Office Witness:_____