Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Heartland Endodontics, PA originates and maintains paper and/or electronic records describing my health and dental history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and a means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and review the competence of healthcare professionals.

I understand and have been provided with a ***notice of privacy practices*** that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.528

I understand that Heartland Endodontics, PA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Heartland Endodontics, PA reserves the right to change their notice and practices at any time provided such changes are applicable by law, and make the new Notice available upon request.

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of Heartland Endodontics, PA treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.
I fully understand and accept the terms of this consent.

_____ _____
Patient's Signature Parent/Guardian

_____ _____
Date Office Use (received by/date)