

MAUREEN M. HOLLEY, D.M.D
CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SS #: _____

Doctor's Name: _____

My personal health information is private and confidential. I understand that my doctor and her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and her staff may use and disclose my personal health information to help provide healthcare to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and her staff would follow the agreed upon limits.

I may cancel my consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or her staff can give me called "Revocation of Consent for Use and Disclosure of Health Information."
2. Writing, signing and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment payment and healthcare options.

If I cancel this consent, my doctor and her staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protection of my privacy. I understand that I have the right to read the "notice" before signing this agreement. My doctor may update this "Notice". If I ask, the doctor or her staff will provide me with the most current "Notice" and it will always be available at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "notice of Privacy Practices." My signature means that I agree to allow my doctor to use the disclose of my personal health information to carry out treatment, payment and healthcare operation.

Patient or Legal Guardian _____
Date

Relationship to Patient