Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Clarence J. Red, D.D.S., Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Clarence J. Red, D.D.S., Ltd's Notice of Privacy Practices for a more complete description of such uses and πdisclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Clarence J. Red, D.D.S., Ltd. reserves the right to revise its Notice of Privacy Policy Practices at any time. A revised Notice of Privacy Protection Practices may be obtained by forwarding a written request to Linzette Red, Privacy Officer, at Clarence J. Red, D.D.S., Ltd. located at 227 North Hammes Avenue, Joliet, Il. 60435.

With my consent, Clarence J. Red, D.D.S., Ltd. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent, Clarence J. Red, D.D.S., Ltd may mail to my home or other designated location any items that would assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential. With my consent, Clarence J. Red, D.D.S., Ltd. may email to my home or other designated location any items that may assist in carrying out TPO.

I have the right to request that Clarence J. Red, D.D.S., Ltd. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Clarence J. Red, D.D.S., Ltd.'s use and disclosure of my health information to carry out TPO. I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Clarence J. Red, D.D.S., Ltd. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name of Patient or Legal Guardian Patient's Name

_____

E-mail Address

Acknowledgement of Receipt of Notice of Privacy Practices

_____
Date

I acknowledge that I,_____, have received the Notice of Privacy Practices.
Print Name

_____
Print Name of Patient

_____
If person signing is a representative, describe the basis for the patient's authority to sign on behalf of patient.

_____
Print Name of signing if different than patient

_____
If person signing is a representative, describe the basis for the patient's authority to sign on behalf patient.

(Please fill out other side)