Patient Consent for Use and Disclosure of Protected Health Information

Oakland Dental Practice
12 Third Avenue | tel.. 501-234-5678 | dean@oaklanddental.com

Our Notice of Privacy Practices outlines how we may use or disclose your protected health information (PHI). By signing this form, you acknowledge having reviewed our notice and give consent for the following uses and disclosures:

Use and Disclosure for Treatment, Payment, and Healthcare Operations:
Your PHI can be used for treatment, obtaining payment for treatment, and internal healthcare operations. This includes, but is not limited to, consultations with other healthcare providers, billing activities, and quality improvement initiatives.

Changes to Privacy Policy:
Our privacy practices are subject to change. Should there be a significant change, you will be notified at your next visit for acknowledgment.

Right to Restrict PHI Use:
You have the right to request restrictions on certain uses and disclosures of your PHI. While we are not required to agree to these restrictions, we will abide by any agreed-upon restrictions.

Revocation of Consent:
You may revoke this consent at any time in writing. However, the revocation will not affect any prior uses or disclosures of PHI made under this

Communication Preferences

Please indicate your preferences for how we may contact you:

Appointment Confirmations
(May we use these methods to confirm appointments?) *

- [ ] Phone
- [ ] Email
- [ ] Text message

Messages
(May we leave messages regarding appointments or other non-sensitive information?)

- [ ] Home answering machine
- [ ] Cell phone voicemail

Family Discussions
(May we discuss your medical condition with designated family members?) *

- ( ) Yes
- ( ) No

If yes, please name the allowed members

Consent

By signing below, I acknowledge that I have read and understood this form and agree to the use and disclosure of my PHI as described above, including the receipt of marketing-related communications if I have opted in. I also acknowledge my rights and the practice's right to change its privacy policy.

Patient's Name *

Patient's Signature *

Draw Your Signature Here

Date *

Patient's phone number *

Patient's email *

Submit