HEALTH DISCLOSURE FORM

Advanced SEDATION DENTISTRY

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CONSENT for RELEASE of PROTECTED HEALTH INFORMATION

Please read carefully and sign below

I, _____, consent to the release of protected health information that is required to carry out the treatment or payment of healthcare operations on my behalf.

I have read the notice of privacy practices and am aware of the following:

- *I have the right to place restrictions on the way my protected health information is used or disclosed.*
- *I understand that Advanced Sedation Dentistry is not required to agree with my requested restrictions. I also understand that once Advanced Sedation Dentistry agrees to my restrictions, it must comply with those restrictions.*
- *I have the right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a signed written request.*
- *I understand that Advanced Sedation Dentistry must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.*
- *Advanced Sedation Dentistry has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices we will modify the notice accordingly; and will inform you on your next visit.*
- *Advanced Sedation Dentistry can discuss my medical and financial information with the following individuals:*

Name of Individual	Relation to Patient (i.e – Doctor, Spouse, Family, etc…)	Phone Number

PATIENT CONSENT

Printed Name

Signature

Date

PARENT / LEGAL GUARDIAN or WITNESS

Printed Name

Signature

Date

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.