

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health 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.
- A means of communication with the healthcare professionals who contribute to my care
- A source of information for applying my dental information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool to assess and review routine healthcare operations.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To revoke this consent in writing
- To request restrictions as to how my healthcare information may be used.

_____ I request the following restrictions to the use or disclosure of my healthcare information: _____

PATIENT:
PRINT NAME _____

SIGNATURE _____

DATE _____