



Prosthodontics Intermedica
 467 Pennsylvania Avenue
 Fort Washington, PA 19034
 215-646-6334

**CONSENT FOR USE AND DISCLOSURE
 OF HEALTH INFORMATION**

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Chart Number: _____ Social Security Number: _____

Section B: To the Patient – Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, a revised Notice of Privacy Practices will be available upon request. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

HIPAA Information Department
Prosthodontics Intermedica
467 Pennsylvania Avenue, Suite 201
Fort Washington, PA 19034
Telephone: 215-646-6334 Fax: 215-643-1149
Email: PITEAM@aol.com
<http://www.dentalimplants-usa.com>

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Prosthodontics Intermedica. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent. I understand that revocation of this Consent cannot be used to delay or refuse payment for any services rendered by us previously.

Please specify which optional disclosures we may use to aid in providing you with the highest quality dental care.

May we thank the person who referred you and mention your name in the communication? Initial
 [] Yes [] No _____

We want to be certain your records and chart accompany you during your treatment. Therefore, may we place your photograph on the cover of your chart?
 [] Yes [] No _____

CONTINUED ...

PAGE 2

I hereby consent to the use, reuse, production and reproduction at any time by Prosthodontics Intermedica or their designees, my likeness or resemblance as presented in photographs of my oral and facial structures and their publication for public and teaching or professional educational and scientific purposes.

In formats as follow:

- On audio/video or other forms of recording [] Yes [] No _____
- On the Internet [] Yes [] No _____
- In printed format [] Yes [] No _____
- Office photo album [] Yes [] No _____

May we use your clinical care and photograph to educate the public? [] Yes [] No _____

I understand that my name and treatment procedure will appear on the daily schedule and computer monitor during the day of my scheduled appointment. **INITIAL HERE** _____

I understand that the nature of the dental practice can allow sound to travel between treatment areas. I am aware that it is my right to request that the door of my operatory be closed to maintain privacy if I desire. **INITIAL HERE** _____

I represent that I am over the age of eighteen years of age. **INITIAL HERE** _____

To whom, other than yourself, may we discuss your treatment in addition to physicians and medical specialists mentioned in your medical history record and health history form?

(Please list all necessary physicians, dentists, family members and others. Without your consent, we cannot speak with anyone regarding your treatment.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SIGNATURE

I have received a copy of the NOTICE OF PRIVACY PRACTICES and I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this Consent after you sign it.