SERENE DENTAL CARE

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Patient Consent Use and Disclosure of Health Information
For Treatment, Payment and or Healthcare Operations

I understand that as part of my health care, Serene Dental Care originates and maintains paper records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plan(s) for future care or treatment.

I understand that this information serves as:

- A basis for **planning** my care and treatment,
- A means of **communication** among the health professionals who contribute to my care,
- A source of **information** for applying my diagnosis and surgical information to my bill,
- A method by which my health plan can **verify** that services billed were actually provided, and
- A tool for routine healthcare **operations** such as quality assessment.

I understand that I have the following rights and privileges:

- The right to **object** the use of my health information for directory purposes, and
- The right to request **restrictions** as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that if I put restrictions on how my health information is used, Serene Dental Care is *not* required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the actions the organization may have already taken. I also understand that by refusing to sign this consent or revoking this consent, Serene Dental Care may refuse to treat me.

I wish to apply the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand and accept the terms of this consent.

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Signature of patient (or parent/guardian if patient is a minor) Date