

# JACKSON FAMILY DENTISTRY

Scott W. Charmoli, D.D.S.

## Consent for use or disclosure of health information

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

### Your Right To Limit Uses Or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

#### **I wish to be contacted in the following manner (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Home Telephone                           | <input type="checkbox"/> Written Communication        |
| <input type="checkbox"/> O.K. to leave message with detailed info | <input type="checkbox"/> O.K. to mail to home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to work address |
| <input type="checkbox"/> Work Telephone                           |   |
| <input type="checkbox"/> O.K. to leave message with detailed info |   |
| <input type="checkbox"/> Leave message with call-back number only |   |

I have read your consent policy and agree to its terms and our disclosure of your patient health record and results for disaster relief purposes as permitted by law, and to the following persons, including those involved in your care or payment for that care. I am also acknowledging that I have received a copy of this notice.

_____	_____	_____
Printed Name (Patient)	Authorized Provider Rep	Date

_____	_____	_____
Signature (Patient or Legal Guardian)	Relationship	Date

This notice becomes effective April 14, 2003