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

I understand that as part of my healthcare, Chesterfield Family Dental, LLC, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, billing information and any plans for future care of treatment. I understand that this information serves as:

- *A basis for planning my care and treatment;*
- *A means of communication among the many health professions who contributes to my care;*
- *A source of information for applying my diagnosis and dental information to my bill;*
- *A means by which a third party payer can verify that services billed were actually provided; and*
- *A means by which payment for services can be made.*

I understand and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosure. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and will provide a copy of any revised notice. I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that organization has already taken action reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Chesterfield Family Dental, PC, unless it agrees to the request in writing.

I understand that for convenience or necessity, I would like my health information available to the following friend or family member *(name relationship and contact number):*

_____ _____

_____ _____

I fully understand and accept the terms of this consent.

_____ _____

Patients name Date

Signature of patient (or guardian if patient is a minor)

Please sign backside