

PROTECTED HEALTH INFORMATION CONSENT

Introduction

Premier Dental Associates, Inc., Inc. must obtain your consent before using or disclosing protected health information, as required by recent federal regulation. "Protected Health Information," includes your demographic information and information regarding your health condition and related treatment. Such information may be used by Premier Dental Associates, Inc., its staff, and others outside our office that are involved in your care and treatment in order to carry out your treatment, payment, and to support the operations of our practice.

Your Rights

You may revoke your consent in writing, unless Premier Dental Associates, Inc. has taken action in reliance on such consent. You are entitled to request restrictions on the use and disclosure of your health information for purposes of providing you with treatment, and Premier Dental Associates, Inc. is bound to any such restrictions to which it agrees.

Before receiving your consent, Premier Dental Associates, Inc. must provide you with a notice of its privacy practices, and you may review that notice prior to signing this consent form.

Consent

I, _____, (your name) hereby consent to the use and disclosure of my protected health information by Premier Dental Associates, Inc., its staff, and others outside its office for the purposes of treatment, payment, and to support the operations of Premier Dental Associates, Inc. practice. I understand that I may revoke such consent only to the extent not relied upon by Premier Dental Associates, Inc. I have been provided with a copy of Premier Dental Associates, Inc. Notice of Privacy Practices.

Signature (patient or representative)

Date