Personal Health Information Disclosure Agreement
for Tomko Dental Associates

I, _____do hereby grant permission for Tomko Dental Associates, to disclose my personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.)

List Name, relationship and phone number:

_____

_____

_____

_____

Information to be disclosed (please check):

- ☐ **Appointment dates and times**
- ☐ **Treatment plans and referrals**
- ☐ **Financial and billing information**
- ☐ **Any other pertinent dental health information related to treatment at this office**
- ☐ **None of the above services**

I understand that this permission will remain in effect unless a written cancellation has been provided to Tomko Dental Associates.

_____ _____

Patient Signature **Date**

_____

Patient's Date of Birth

OVER.....

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Guidelines effective September 2015

Name:_____ Date of Birth:_____

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, and of other important matters about your protected health information and of other important matters about 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, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation sub mitted to the Contact Person listed on the Notice of Privacy Practices (pg. 3). Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocations, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

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 health care 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:_____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

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:_____