Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Sky Dental to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and health care operations.
I have the right to review Sky Dental's Notice of Privacy Practices prior to signing this consent. Sky Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Abby Hussamy at Sky Dental.

With this consent, Sky Dental may:

1. Call / text my home or other alternative provided contact numbers and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
2. Mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminder cards and patient statements.
3. E-mail me any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders and patient statements.
4. File insurance claims related to your treatment.

I have the right to request that Sky Dental restrict how it uses or discloses my protected health information to carry out treatment, payment, and health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sky Dental may decline to provide treatment to me.

Patient Acknowledgement

- ✓ I acknowledge that I have read, and I understand, and I agree to Sky Dental's Notice of Privacy Practices.
- ✓ By signing this form, I am consenting to allow Sky Dental to use and disclose my protected health information to carry out treatment, payment, and health care operations as explained in this form.
- ✓ I am also consenting to allow my Parents | Spouse to use and disclose my Protected Health Information (PHI).

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please Print Name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient

Thank you, and Welcome to Sky Dental! administrator@myskydental.com
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