Dr. Virginia Mattson

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:_____

In connection with the dental services that I am receiving from the above named dentist, I hereby authorize the above named dentist and/or group to use and disclose any and all information concerning my health condition , including copies of applicable dental records to:

A. Any third party payer covering the dental services of the patient
B. Other health care professionals and institutions involved in the delivery of health care to the patient.
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for each services.
E. Pharmacies
F. Other parties as otherwise required by law.

In each case the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the dental's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed:_____

Date:_____

Witness:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____