770.992.6568
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SHENK DENTAL CARE

Judd W. Shenk, DMD

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Shenk Dental Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Shenk Dental Care's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent and receive a copy if I so desire. Shenk Dental Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice may be obtained by forwarding a written request to Shenk Dental Care at the office location.

With this consent, Dr. Shenk's office may call my home, office or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Shenk's office may mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, insurance forms or information, and patient statements. I have the right to request Dr. Shenk's office to restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this.

By signing this form, I am consenting to Dr. Shenk's use and disclosure of my PHI to carry out TPO,
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, I understand that I will be financially responsible for any dental work provided by this office.

_____
Print Patient's Name

_____ _____
Signature of Patient or legal Guardian | Print Name of legal Guardian

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FOR OFFICE USE ONLY

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my PHI for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my consent. _____

Signature_____ Date_____