CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

updated guidelines effective August 2013

Dr. Austin and Dr. Reid

Name: _____ Birthdate: _____

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. **A copy of our Notice is available to you to read in our office or take home with you.** 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 submitted to the contact person listed on the privacy forms. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

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, insurance companies and dentists, I give my permission for this.

Signature: _____Date: _____

Personal Health Information Disclosure Agreement
For Drs. Austin and Reid

I, _____, do hereby grant permission for Dr. Austin or Dr. Reid and/or staff members to disclose my personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.) PLEASE WRITE NONE IF YOU DO NOT WANT ANY INFORMATION GIVEN TO ANYONE.

- _____
- _____
- _____

Information to be disclosed:

- Appointment dates and times _____
- Treatment plans and referrals _____
- Financial and billing information _____
- Any other pertinent dental health information related to treatment here. _____
- None of the above _____

I understand that this permission will remain in effect unless a written cancellation has been provided to Dr. John Austin or Dr. Ross Reid and/or staff.

Patient signature: _____ Date:_____

Patient's Birthdate: _____

Witness signature: _____ Date: _____

Privacy official: Diane Southworth
Telephone: (810)733-8890 Fax: (810)733-6631
Address: 4256 S. Linden Road, Flint, MI 48507
Email: austinandreid@hotmail.com