CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to CITY CREEK DENTAL using and disclosing my protected health information to carry out treatment, payment or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing the consent.

I understand that CITY CREEK DENTAL reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to CITY CREEK DENTAL, 803 S 37th St, Temple, TX 76504.

I understand that I have the right to restrict how CITY CREEK DENTAL uses or discloses my protected health information to carry out treatment, payment or health care operations and that CITY CREEK DENTAL is not required to agree to the restrictions and that CITY CREEK DENTAL is bound by restrictions to which it agrees.

I request that the following restrictions to how my health information is used or disclosed:

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I have the right to revoke this consent by notifying CITY CREEK DENTAL in writing, except to the extent that CITY CREEK DENTAL has taken action in reliance on my consent.

_____ _____

Signature of patient or representative Date

_____

Printed name of patient or representative