FishHawk
ORAL SURGERY
Dr. Patrick A. Abbey, D.M.D., P.A.

PATIENT CONSENT FOR USE, DISCLOURE OF REQUEST OF HEALTH INFORMATION

FOR TREATMENT OR PAYMENT

Patient Name: _____

As part of your healthcare, this practice originate and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment.
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

"ONLY AS PERMITTED BY STATE OR FEDERAL LAW", you are giving this practice consent to do the following:

- **To disclose, as may be necessary, your health information (including HIV status, drug/alcohol abuse and psychiatric notes) to other healthcare providers (such as, referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**

- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.**

- **To submit diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of our services.**

- **Leave appointment reminders or information we believe necessary for treatment or payment, (please check one, both or neither). On an answering machine ( ) or with a member of your household ( ). The information will be the minimum necessary in our professional judgement.**

- **Discuss your health information (only as necessary in our judgement) with family members or other persons who are or may be involved with your healthcare treatment or payments.**

- **Please list by name and relationship persons with whom we may not share your healthcare or payment information _____**

You may request a copy of our ***"Notice of Patient Privacy Practices"*** that provides a more complete description of health information uses and disclosures as required by the HIPPA standard. You also have the right to read the ***"Patient Health Information Privacy Practices"*** prior to signing this consent.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____ _____ _____

Signature Print name of person signing Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes ( ) No ( ) RELATIONSHIP_____. If you are not the parent, please provide a copy of your legal authority for this patient.

_____

FOR OFFICE USE ONLY

( ) Patient refused to sign the consent form. Reason for patient refusal to sign _____