

Ligon Dental Group

5201 Central Avenue, Saint Petersburg, FL 33710

Phone 727-321-7880 / Fax 727-327-6484

**Patient Consent to the Use and Disclosure of Health Information**

**For Treatment, Payment, or Healthcare Operations, Per HIPAA Regulations**

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the health professionals who contribute to my care, such as referrals,
* A source of information for applying my diagnosis and treatment information to my bill,
* A means by which a third-party payer can verify that services billed were actually rendered,
* A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

**I have been provided with a “Notice of Patient Privacy Practices” that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

* The right to review the **“Notice”** prior to acknowledging this consent,
* The right to restrict or revoke the use or disclosure of my health information for other uses or purposes,
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

**PLEASE PRINT**

**Restrictions:**

**\*\*I request the following restrictions to the use or disclosure of my health information:**

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**\*\*Please tell us with whom we may discuss your protected health information:**

(For example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s))

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**\*\*Messages or Appointment Reminders:**

May we leave a message at your **home** using doctor's/practice name: Yes { } No { }

May we leave a message at your **work** using doctor's/practice name: Yes { } No { }

**Messages will be of a non-sensitive nature, such as, appointment reminders.**

**I understand that as a part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other health care providers. I consent to such disclosure for these uses as permitted by law.**

\*\*I fully understand and **accept / decline** (*please circle one)* the information of this consent.

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Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Person Signing

\*If other than the patient (Patient Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is signing, are you the legal guardian, custodian or have the Power of Attorney for this patient, for treatment, payment or health care operations? Yes { } No { }

**FOR OFFICE USE ONLY**

{ } Consent form received and reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on\_\_\_\_\_\_\_\_\_\_\_\_\_

{ } Consent form signature refused by patient.

{ } Patient unable to sign consent form. Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_