WATERVILLE COMMUNITY DENTAL CENTER

2 Evergreen Drive, Oakland, ME 04963 (207) 861-5801

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the Community Dental Center's use of my protected health information ("PHI") in support of my diagnosis and treatment, payment for the services I receive and the legitimate operations of the dental practice.

I consent to the Community Dental Center's disclosure of PHI to other health care practitioners and facilities that are involved in providing services to me and my family and to close friends who are providing me with emotional support as I receive services. Also, I consent to the Community Dental Center's disclosure of PHI to my dental insurance carrier, utilization review organization or third party administrator to support payment for my dental services.

I understand that the Community Dental Center's agreement to provide dental services to me is conditional upon me signing this consent and that the Community Dental Center requests my consent to ensure that the Community Dental Center can properly carry out the professional responsibility of caring for me.

I understand that the Community Dental Center will disclose only the minimum amount of my information, which is necessary, in the judgement of the Community Dental Center, for the legitimate needs of the recipient or for my general well-being.

I understand that I have the right to restrict the Community Dental Center's use and disclosure of my PHI and that the Community Dental Center is not obligated to agree to the requested restriction, but that an agreement to a restriction binds the Community Dental Center. I may revoke this consent at any time by providing the Community Dental Center with a written, signed and dated request except to the extent that the Community Dental Center has acted in reliance upon my consent. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

I understand that the Community Dental Center regards the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with the Community Dental Center.

I have received a copy of the Community Dental Center's Notice of Privacy Practices that provides a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice of Privacy Practices before signing this consent. I acknowledge that the Community Dental Center reserves the right to amend the Notices of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.

I understand that if I have any questions about this consent or about the Community Dental Center's privacy practices, or if I wish to have a copy of this consent, I may ask the office staff or my provider.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Parent/Legal Guardian Date