Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information Beautiful Smiles Family Dentistry for the purposes of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Beautiful Smiles Family Dentistry. I understand that diagnosis or treatment of me by **Dr. Francois** or her Associates maybe conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of the practice. Beautiful Smiles Family Dentistry is not required to agree to the restrictions that I may request. However, if Beautiful Smiles Family Dentistry agrees to a restriction that I request the restriction is binding on Beautiful Smiles Family Dentistry and **Dr. Francois** or her Associates.

I have the right to revoke this consent in writing at any time except to the extent that **Dr. Francois** or her Associates or Beautiful Smiles Family Dentistry has taken action in reliance on this consent.
My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Beautiful Smiles Family Dentistry's Notice of Privacy Practices prior to signing this document. The Beautiful Smiles Family Dentistry's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment payment or my bills or in the performance of health care operations of Beautiful Smiles Family Dentistry. The Notice of Privacy Practices also describes my rights and Beautiful Smiles Family Dentistry's duties with respect to my protected health information.

Beautiful Smiles Family Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment

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Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Person Representative's Authority