The Kids Spot dentistry

Chris S. Potts, D.D.S., P.A.

GENERAL DENTISTRY

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Patient's Name: _____ Date of Birth: _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information. I understand that my doctor and his staff ay use and disclose my personal health information to help provide health care to me, to handle billing, payment and to take care of other health care operations. There will be no other uses or disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission. I can ask my doctor to limit how my personal health information is used and disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree with my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits. I may cancel this consent at any time by doing the following:

> Writing, signing and dating a letter to my doctor that states that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me. My doctor has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my privacy. I understand that I have to right to read the Notice before signing the agreement. My doctor may update his Notice. If I ask, my doctor or his staff will provide me with the most current Notice. My signatures means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and health care operations.

I hereby request and authorize insurance company benefits be made on my behalf to Dr. Chris Potts for any services furnished to me by that physician/supplies. I authorize any holder of medical information about me to release to insurance companies or their agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information needed to pay the claim. Full charges are sent to my insurance company. I am responsible for deductible, coinsurance and non-covered services. Insurance payment and the deductible are based upon the determination of my insurance company and are independent of amounts charged by The Kids Spot Dentistry.

*List all family members, friends and/or physicians who are authorized to call and receive test results and information concerning the health care from this facility.*

_____ _____

Parent/Legal Guardian Date

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Relationship to patient (parent, legal guardian, etc.)