GARY S. DAVIS FAMILY DENTISTRY

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for GARY S. DAVIS FAMILY DENTISTRY to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. GARY S. DAVIS DENTISTRY reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to

Gary S. Davis DDS
420 East Orange Street
Shippensburg, PA 17257

With this consent, GARY S. DAVIS FAMILY DENTISTRY may call or text my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, GARY S. DAVIS FAMILY DENTISTRY may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, GARY S. DAVIS FAMILY DENTISTRY may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that GARY S. DAVIS FAMILY DENTISTRY restrict how it uses or disclose my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow GARY S. DAVIS FAMILY DENTISTRY to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it GARY S. DAVIS FAMILY DENTISTRY may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

_____
Date

_____
Print Legal Guardian's name (if any)