

Michael G. Moore DDS

Patient Consent for Use and Disclosure of Protected Health Information

1. I have received a copy of the Notice of Privacy Practices, AND I have reviewed my rights and the practices responsibilities with respect to private health information as outlined in the practice's Notice of Privacy Practices.
 2. I give my consent for this office to use and disclose protected health information about me to carry out my treatment and to collect full payment for services.
 3. I give my consent for this office to transmit my treatment records (including X-rays) by both regular mail and email to other providers involved in my treatment;
 4. I permit a copy of this authorization be used in place of the original.
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With this consent, our office may call your home or other alternative location, and leave a message on your voice mail or answering service regarding appointments, insurance-related questions, and any other calls pertaining to your care, including questions relating to your account balance.

Home _____ Work _____
Cell _____ Alternate _____
Email _____

With this consent, our office may mail to your home or other alternative location any items that assist the practice in carrying out treatment and collecting full payment for services. This includes appointment reminder cards and statements

If you want any correspondence such as billing statements, appointment reminders, etc sent to an address other than your home address, please print the alternative address on the line below:

Alternate Address: _____

Please list the names of any person(s) with whom we may discuss matters relating to your treatment including appointments, financial and other matters relating to your treatment.

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____

By signing below, I consent to everything listed in the page above. I may revoke my consent in writing except to the extent that the practice has already made disclosures in compliance with prior consents.

Signature: _____

Print Name: _____

Date: _____