Drs. Warren & Hardee, P.A.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information. We may have to disclose your health information to another health care provider or a dental lab if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of your services. We may need to use your health care information with our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review this notice before you sign this consent form. We reserve the right to change our privacy practices described in that notice. If we make changes to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

You may revoke your consent to us at any time; however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your dentist and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you by home phone, work phone, e-mail, cards or letters with appointment reminders about your treatment alternatives or other health related information that may be of interest to you. If this contract is made by phone and you are not at home or at work, a message may be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact you with these reminders and information.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by federal privacy rules. If you do not give us authorization, it will not affect the treatment we provide you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

This notice is effective as of April 14, 2003. This authorization will expire seven years after the date on which you last received services from us.

I have read your consent policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

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Patient Name (Print)   Date

_______________________   _______________________

Patient or Guardian Signature   Authorized Provider Representative