THE ROOT CANAL GUY

James Wolcott D.D.S

Patient Consent/Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. James Wolcott, our staff and our business associates (your general dentist, other specialists and your insurance) for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice. We will post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree on these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgment of receipt of **OUR NOTICE** of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the consent of the notice of privacy.

Print Name _____ Date_____

Signature _____

If refused, please specify the exact reason why the patient chose not to sign the consent/acknowledgement of notice of privacy. All forms are for educational use only and do not constitute legal advice. All forms are subject to changes in the federal law and applicable state laws. Seek legal advice before use.