Consent and Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

WATSONVILLE FAMILY DENTAL
high-quality & cost-effective dental care, without exception

Patient: _____ Date of Birth: _____

I understand that as a part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who may contribute to my healthcare;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

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Signature of Patient or Legal Representative

_____ _____

Printed Name of Patient or Legal Representative Date