Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by the office of Dr. Derek Borgwardt and Dr. Sarah Rinehart for the purpose of diagnosing or providing treatment to me, obtaining payment for my dental health care bills, or treatment of me by the office of Dr. Borgwardt and Dr. Rinehart may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The office of Dr. Borgwardt and Dr. Rinehart is not required to agree to the restrictions that I may request. However, if the office of Dr. Borgwardt and Dr. Rinehart agrees to a restriction that I request, the restriction is binding on the office of Dr. Borgwardt and Dr. Rinehart.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of Dr. Borgwardt and Dr. Rinehart has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my dentist, another health care provider, a health or dental plan, my employer or a dental care clearinghouse. This proctected health information relates to my past, present, or future dental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Dr. Borgwardt and Dr. Rinehart. The Notice of Privacy Practices is posted at the reception desk. This Notice of Privacy Practices also describes my rights and the duties of Dr. Borgwardt and Dr. Rinehart with respect to my proctected health information.

I allow_____(name)_____(relationship to patient) access to my dental records and information if requested.

Dr. Borgwardt and Dr. Rinehart reserves the right to change the privacy practices that are describes in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

_____ _____

Name of Patient or Personal Representative Date

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Signature of Patient of Personal Representative