George A. Barth D.M.D.
Mark J. Danner D.M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I UNDERSTAND THAT, UNDER THE FEDERAL HIPAA ACT, I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION

With my consent, Dr. Barth and/or Dr. Danner may use and disclose protected health information about me and carry out **treatment, payment and healthcare operations.**

(Please refer to Barth & Danner's Notice of Privacy Practices for a more complete description of such uses and disclosures). I have had the opportunity to review the Notice of Privacy Practices prior to signing this consent.

Dr. Barth and/or Dr. Danner reserve the right to revise this Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this office.

The following consents are hereby authorized:

With my consent, Dr. Barth and/or Dr. Danner's staff may **telephone** my home or other location such as workplace and **leave a message** on an answering device or in person in reference to any items that assist the practice in carrying out **treatment, payment and healthcare operations**, such as appointment reminders, insurance items and may call these locations with messages pertaining to my clinical care, including laboratory results, and billing matters, among others.

With my consent, Dr. Barth and/or Dr. Danner's staff may **mail** to my home or other designated location any items that assist the practice in carrying out **treatment, payment and healthcare operations**, such as **appointment reminder cards and bills.**

I have the right to request that Dr. Barth and/or Dr. Danner's staff restrict how it uses or discloses my **protected health information** to carry out **treatment, payment and healthcare operations.** However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am **consenting** to the use and disclosure of my **protected health information** to carry out **treatment, payment and healthcare operations**. We will not share our information with third parties for marketing purposes.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Barth and/or Dr. Danner's may decline to provide treatment to me.

Signature of Patient or Legal Guardian: _____

Date:

_____
Print Name