SONRISA: A PERIODENTAL SPA

NOTICE OF PRIVACY PRACTICES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **SONRISA** may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPHO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **SONRISA** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Noticed of Privacy Practices may be obtained by forwarding a written request to **SONRISA** Privacy Officer at 508 Indiana Avenue, Indianapolis, IN 46202.

With my consent, **SONRISA** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **SONRISA** may mail to my home or other designated location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **SONRISA** may e-mail to my or other designated location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements. I have the right to request that **SONRISA** restrict how it uses or discloses my PHI to carry out TPHO. 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 **SONRISA'S** use and disclosure of my PHI to carry out TPHO.

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, **SONRISA** may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____ ________________

Patient's Name Date

____

Print Patient Name or Legal Guardian