PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pediatric Dentistry of Mullica Hill (PDMH) to use and disclose protected health information about me or my child to carry out treatment, payment and healthcare operations. Pediatric Dentistry of Mullica Hill's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. PDMH reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, PDMH may call my home (or other alternative location), email or leave a message on voice mail in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my child's clinical care. With this consent, PDMH may mail to my home (or other alternative location) any items that assist the practice in these operations, such as appointment reminder cards and patient statements. By signing this form, I am consenting to PDMH's use and disclosure of my protected health information to carry out healthcare operations. 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, or later revoke it, PDMH may decline to provide treatment to me or my child.

This consent is signed by patient or legal representative:

X_____ **Date:** _____

I authorize disclosure of any of the patient's medical records to the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____