JAMES A BEDOR, DDS, PC

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PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

PATIENT'S NAME: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

NAME: _____

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT **JAMES A BEDOR, DDS PC** WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT **JAMES A BEDOR, DDS, PC** MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO ME, TO HANDLE BILLING AND PAYMENT, AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK **JAMES A BEDOR, DDS, PC** TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT **JAMES A BEDOR, DDS, PC** DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT **JAMES A BEDOR, DDS, PC** MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRITING, SIGNING, AND DATING A LETTER TO **JAMES A BEDOR, DDS, PC** THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, **JAMES A BEDOR, DDS, PC** IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

_____ _____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

_____

RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)