CONSENT FOR USE AND DISCLOSURE

OF HEALTH INFORMATION

FOR THE OFFICE OF J. TIM RUSSIN, DDS, PA

TO THE PATIENT – PLEASE READ:

I HAVE BEEN PROVIDED THE OPPORTUNITY TO READ AND REVIEW THE "Notice of Privacy Practices" for the office of J. Tim Russin, DDS, PA. The Notice describes our office privacy practices, our legal duties, and your rights concerning your private health information. I have been given the opportunity to have any questions that I may have concerning the Notice to be answered, and a written copy of the Notice has been made available to me.

I understand that I have a right to withdraw from this Consent at any time by giving Dr. Russin's office written notice of this intent. Please understand that withdrawal from this Consent will not affect any action our office took in reliance on this Consent before we received your withdrawal, and that our office may elect to discontinue treatment if your Consent withdrawal may compromise your case, health, and/or the safety of you or our staff.

I also understand that I have the right to specifically restrict the use or disclosure of my health information. Please allow for the release of my health information to:

_____ Referring office(s) or restorative dentists treating you.

_____ Our partnered anesthesiologist(s), RN's, LPN's

_____ Other:____

I prefer that my healthcare information will not be used or disclosed to the following individuals, businesses or institutions:

Please list their names and relationship below:

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Messaging and appointment reminders: Please be advised that our staff will attempt to remind you of a scheduled or recall appointment, check your progress after a treatment procedure, or contact you about financial policy/payments concerning your case. By your request, we can call you at home, work, cell phone, fax, e-mail, regular mail, or postcards. You have the right to restrict contacts by your request (i.e. "Don't call me at work", or "Don't call my ex-spouse, etc.). Please list those specific restrictions below, or any instructions that could help insure your privacy in any way:

____

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form (which is optional), I am giving my permission to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: **X**____________________________________ Print Name: _______________________________Date:__________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____ Relationship: ________________________________