Center of Carewell Dentistry Consent Form

I give CENTER OF CAREWELL DENTISTRY, PLLC (“The Practice”) my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice notice of privacy practice (for a more complete description or uses and disclosures) before signing this consent.

I understand that The Practice has the right to change its privacy practice and that I may obtain my revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that The Practice is not required to agree to the request. If The Practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Name: _____

Signature: _____Date:_____

Patient, parent or legal guardian

If signed by patient representative, state relation to patient _____