Patient Consent for Use and Disclosure of Protected Health Information

Use of this form is optional and not required under the HIPAA privacy rule.

I hereby give my consent for **Alpine Family Dental** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Alpine Family Dental** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent,
Alpine Family Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Dr. Sharmila Chopra DDS**

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

With this consent, **Alpine Family Dental** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential"

With this consent, **Alpine Family Dental** may e-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Alpine Family Dental restricts how it uses or discloses my PHI to carry out TPO. 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 allow **Alpine Family Dental** to use and disclose my PHI to carry out TPO.

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, **Alpine Family Dental** may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Print Patient's Name
Date	Print Name of patient or Legal Guardian, if applicable