SUSAN HENSON
DMD, PA

Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for Susan Henson, DMD 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 describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Susan Henson, DMD 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 Susan Henson, DMD 811 N. Water Street, Burnet, TX 78611.

With this consent, Susan Henson, DMD may call my home or other alternative 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, Susan Henson, DMD 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.

With this consent, Susan Henson, DMD may email 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. I have the right to request that Susan Henson, DMD restrict how it uses or disclosed 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 Susan Henson, DMD 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, Susan Henson, DMD may decline to provide treatment to me.

Print Name of Patient or Legal Guardian, if applicable_____

Signature of Patient or Legal Guardian:_____

Patient's Name:_____

Date:_____/_____/_____