CONSENT FOR

PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned, hereby execute this Consent for Purposes of Treatment, Payment, and Healthcare Operations (this "Consent") as written evidence of my consent to the use or disclosure of my protected health information (as defined below) by ***Renwick Family Dentistry Practice*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *Renwick Family Dentistry*. I understand that diagnosis or treatment of me by *Renwick Family Dentistry* may be conditioned upon execution of this Consent.

I understand that my "protected health information" for purposes of this Consent is health information, including demographic information that: (i) is created or received by *Renwick Family Dentistry*; (ii) relates to my past, present or future physical or mental health or condition, the provision of health care to me, or the past, present or future payment for the provision of health care to me; and (iii) identifies me or for which there is a reasonable basis to believe the information can be used to identify me.

Right to Review Notice of Privacy Practices

I understand I have a right to review *Renwick Family Dentistry* Notice of Privacy Practices prior to signing this document for a more complete description the types of uses and disclosures of my protected health information that will occur in my treatment payment of my bills or in the performance of health care operations of the *Renwick Family Dentistry*. A copy of *Renwick Family Dentistry's* Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the Notice of Privacy Practices for *Renwick Family Dentistry*. This Notice of Privacy Practices also describes my rights and *Renwick Family Dentistry* duties with respect to my protected health information.

I understand that *Renwick Family Dentistry* reserves the right to change its privacy practices that are described in the Notice of Privacy Practices and by executing this consent, I agree that *Renwick Family Dentistry* has informed me that the terms of the Notice of Privacy Practices may change and that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Right to Request Restriction

I understand I have the right to request that *Renwick Family Dentistry* restrict how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations and that *Renwick Family Dentistry* is not required to agree to the restriction that I may request. However if *Renwick Family Dentistry* agrees to a restriction that I request, the restriction is binding on *Renwick Family Dentistry*.

Right to Revoke Consent in Writing

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that *Renwick Family Dentistry* has taken action in reliance on this consent.

Signature of Patient or Personal Representative:_____ Date: _____

Name of Patient (Print): _____