

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY EDWARD L. SCHWARTZ DDS PA FOR THE PURPOSE OF DIAGNOSING OR PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT HEALTH CARE OPERATIONS OF EDWARD L. SCHWARTZ DDS PA. I UNDERSTAND THAT DIAGNOSIS OR TREATMENT OF ME BY EDWARD L. SCHWARTZ DDS PA, MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT.

I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS HOW MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS OF THE PRACTICE, EDWARD L. SCHWARTZ DDS PA, IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF EDWARD L. SCHWARTZ DDS PA, AGREES TO RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON EDWARD L. SCHWARTZ DDS PA, AND EDWARD L. SCHWARTZ DDS.

I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT EDWARD L. SCHWARTZ DDS PA OR EDWARD L. SCHWARTZ DDS HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT

MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER OR A HEALTH CARE CLEARINGHOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND IDENTIFIES ME, OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

I UNDERSTAND I HAVE A RIGHT TO REVIEW EDWARD L. SCHWARTZ DDS PA'S NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THE EDWARD L. SCHWARTZ DDS PA NOTICE OF PRIVACY PRACTICES HAS BEEN PROVIDED TO ME. THE NOTICE OF PRIVACY PRACTICES DESCRIBES 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 EDWARD L. SCHWARTZ DDS PA. THE NOTICE OF PRIVACY PRACTICES FOR EDWARD L. SCHWARTZ DDS PA IS POSTED AT 7300 MCNAB ROAD # 115 TAMARAC, FL 33321. THIS NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE EDWARD L. SCHWARTZ DDS PA'S DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

EDWARD L. SCHWARTZ DDS PA RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES CALLING THE OFFICE AND REQUESTING A REVISED COPY BE SENT IN THE MAIL OR ASKING FOR ONE AT MY NEXT DENTAL APPOINTMENT. AT THE TIME NO WEBSITE IS AVAILABLE TO OBTAIN INFORMATION.

SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE

NAME OF PATIENT

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY__