

J. DAVID CIVILS, DDS, PA

***CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION***

Patient's Name (PLEASE PRINT)

Date

By signing this form I hereby give permission for the practice of Dr. David Civils to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). A copy of our *Notice of Privacy Practices* provides a more complete description of such uses and disclosures. (A notice is posted in our business office or a personal copy is available on request.) You have a right to review this notice prior to signing this consent and understand that you have the right to revoke this Consent at any time by giving us written notice at the address below.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices.

With this consent, the practice of Dr David Civils may call me in reference to any item that assists the practice carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. In addition, the practice may mail to my home or alternative location any items such as appointment reminders, x-rays/patient records, insurance items and patient statements.

I have the right to request that Dr. David Civils restrict how they use or disclose my PHI to carry out TPO.

Signature of patient (If under 18, signature of parent or guardian)

Date

1114 Magnolia Street – Greensboro, NC – 27401

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____