BV Dental
COSMETIC & LASER DENTISTRY

Patient Consent Form

Use and Disclosure of Health Information Protected under HIPPA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Dental director of this facility.
I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent of disclosures have been made in reliance upon my prior consent.
I hereby consent that photographs may be taken during my Treatment to be used in a manner for dental programs developed on behalf of **BV Dental**. I give my permission for these photographs to be used for educational purposes. I understand that my name will not be published on any of these materials beyond documentation for my chat.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Patient's Name:_____ **Date:**_____

Patient's Signature:_____ **Relation:**_____
(If applicable, Legal Guardian)