

I, \_\_\_\_\_, have received a copy of Dr. Steven Ellinwood's Notice of Privacy Practices.

I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This includes transfer of any records, personal information and/or discussion with any facility we do business with regarding your dental treatment, or account status.

I have the right to read the Notice of Privacy Practices before I decide to sign the consent below. And have been given, or offered a copy of the Notice of Privacy Practices.

Dr. Ellinwood reserves the right to change the privacy practices as described in the Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Please note that revocation of your consent must be in writing. Complaint form may be requested.

(PLEASE CIRCLE)

May we leave detailed messages on your answering machine at home?    NA    YES    NO

If NO, we will leave a brief confirmation/reminder, or request to call on your machine.

May we call you at work?    NA    YES    NO

May we leave a detailed message on your Voice Mail at work?    NA    YES    NO

If NO, may we leave a brief confirmation/reminder on your Voice Mail?    NA    YES    NO

May we leave a message with a secretary or coworker?    NA    YES    NO

May we contact you by email?    NA    YES    NO

If YES, Email Address to use \_\_\_\_\_

May we discuss your care and/or account with others in your household?    NA    YES    NO

If so, please tell us who: (names) \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Signature of Parent or Guardian if Minor Child)