## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Snodgrass-King Pediatric Dental Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

With this consent, Snodgrass-King Pediatric Dental Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

Home Phone # ____________________________ Alternative Phone # ________________________________

With this consent, Snodgrass-King Pediatric Dental Associates may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Snodgrass-King Pediatric Dental Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as treatment plans and estimates, patient statements or receipts and appointment reminders.

E-Mail address ____________________________________________________________

Alternative E-Mail address ____________________________________________________

The following people listed below have my permission to access and receive my PHI :

| Name | Relationship |
|---|---|
| ________________________ | ________________________ |
| ________________________ | ________________________ |
| ________________________ | ________________________ |

I, ________________________________, have read the contents of this Consent Form. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

______________________________________________ ________________________

Patient's Signature or Signature of Patient's Representative Date

______________________________________________ ________________________

Printed Name of Patient's Representative Relationship to Patient