



Clark College
Dental Hygiene Department

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I hereby give my consent for this institution to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by this institution describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. This institution reserves the right to revise its Notice of Privacy Practices at any time. With this consent, this institution may call my home or other alternative location and leave a message on voicemail 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.

With this consent, this institution may mail or email 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.

I have the right to request that this institution restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow this institution to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, this institution may decline to provide treatment to me.

I have reviewed this institution's Notice of Privacy Practices and have:

- declined a copy.
- received a copy.

Signature of Patient or Legal Guardian

Date

Print Patient or Legal Guardian Name

Date

Relationship to Patient