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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I Hereby acknowledge receipt of a written notice of my privacy rights and I consent to FAMILY DENTISTRY using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, Which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that FAMILY DENTISTRY reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written requested address to CARMELITA PANGANIBAN, c/o FAMILY DENTISTRY, 914 EAST 8TH STREET, SUITE 208, NATIONAL CITY, CA 91950.

I understand that I have the right to restrict how FAMILY DENTISTRY uses or discloses my protected health information to carry out treatment, payment or health operations; that FAMILY DENTISTRY is not required to agree to the restriction and; that FAMILY DENTISTRY is bound by restrictions to which it agrees.

I REQUEST THE FOLLOWING RESTRICTIONS TO HOW MY HEALTH INFORMATION IS USED OR DISCLOSED:

I have the right to revoke this consent by notifying FAMILY DENTISTRY in writing, except to the extent the FAMILY DENTISTRY has taken action in reliance on my consent.

Signature of patient or patient's representative

Date

Printed Name of patient or patient's representative

Relationship to patient representative or Authority to act for this patient.