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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 heath 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:

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