JUST FOR GRINS
family dentistry

Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ Date of Birth: _____

I understand that Just For Grins may use and disclose my protected health information for the purpose of treatment, payment of bills or in the performance of health care operations of Just For Grins. I may obtain a copy of the Notice of Privacy Practice at any time upon request. The Notice provides a description of the uses and disclosures Just For Grins may make of my protected health information. Protected health information refers to any health information, such as the information collected from me and created or received by my doctor, another health care provider, a health plan, employer or a heath care clearinghouse. This information relates to my past, present or future health or condition and there is reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment, obtaining payment for my health care services or to conduction health care operations. Heath care operations may include email reminders, phone calls, texts and correspondence asking for feedback or inviting me to share my experiences via surveys and/or social media.
I have the right to revoke this consent, in writing, at any time. If I choose to revoke this consent, I understand that the doctor or practice may have already released information based on my original consent.

I understand that if I would like to authorize the release of protected health information to any person other than myself (parents, spouse, children, etc) they must be listed below. This information may include: diagnosis, records, examination, treatment rendered, ledger, billing and claims information. My protected healthcare information may be released to:

_____

_____

As a service to our patients, we may provide courtesy appointment reminders or other calls, emails and/or texts. By providing us with this information, you consent to receiving such calls/emails/texts.

_____ _____
Signature of Patient or Personal Representative Date

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____