Aaron Memon DMD

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPPA

With my consent, Aaron Memon, DMD may use and disclose protected health information [PHI] about me to carry out treatment, payment and healthcare operations[TPO]. Please refer to Aaron Memon, DMD Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Aaron Memon, DMD serves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Aaron Memon, DMD 14500 Tamiami Trail, North Port, Fl. 34287.

With my consent, Aaron Memon, DMD may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Aaron Memon, DMD may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Aaron Memon, DMD may e-mail to my home or other designated 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 Aaron Memon, DMD restrict how it uses or disclosed my PHI to carry out TPO. However, 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 Aaron Memon, DMD use and disclosure of 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, Aaron Memon, DMD may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Patient/Legal Guardian

_____ _____

Patient's Name Date