

MITCHELL POISET, D.D.S., A.P.C.

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Mitchell Poiset D.D.S., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (858) 492-9977 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.
I HAVE REVIEWED, AND UNDERSTAND SPECIFICALLY (PARAGRAPH 1A) OF THE NOTICE OF PRIVACY.

INITIAL

Signature _____ Date _____

PLEASE SPECIFY A DETAILED REASON WHY PATIENT CHOSE NOT TO SIGN
THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.
