SMILEORA, LLC
ANIL MEHTA, DDS
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name of Patient: (print name)_____

I, the undersigned, hereby authorize payment directly to SmileOra, LLC of dental benefits, if any, otherwise payable to me under the terms of my dental insurance. I understand if my dental insurance does not cover any service I receive, then I will be responsible for that non-covered service.

I fully understand that I am primarily and financially responsible for fees incurred; I further understand that payment to doctor is not contingent upon any settlement, judgement or verdict by which the above patient may eventually recover said dental fees.

I hereby authorize dental treatment, care, and/or services by SmileOra, LLC and to release any information acquired in the course of examination of treatment to any doctor I may be referred to by SmileOra for further treatment.

I hereby authorize SmileOra, LLC to provide any treatment in the course of my examination. I also authorize the release of information and assign insurance benefit payments.

I herby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to SmileOra, LLC.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

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

Personal Representative's Name: _____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____