Consent Form for Use or Disclosure of Patient Health Information

You have the right to restrict the uses and disclosures of your Protected Healthcare Information (PHI) for the purpose of your treatment, payment for your services and the healthcare operations of **Vincent P. Lim, D.D.S**, however we are not required to agree to requested restrictions but we are bound by any restrictions agreed upon.

Permission to release Your Protected healthcare Information to Family Members or Others

Please mark whether or not you choose to authorize us to release your information to family or others:
__ No __ Yes
(If yes, please indicate the individual name(s) below.)

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures or use other description)*_____

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Your signature below acknowledges:

- You have read and understand this consent.
- You agree to have the PHI used and disclosed by Vincent P. Lim, D.D.S. for the purpose of your treatment, to secure payment for your treatment and for healthcare operations.
- You are permitting the release of your PHI to the persons noted above. You understand the receiving party may not further disclose this health information without first obtaining a new written authorization you.
- You are aware that you may now or at any time revoke the use and disclosure of your PHI. This request must be done in writing. It will not affect any use or disclosures permitted by your authorizations prior to receiving your revocation.

Printed Patient Name	Date of Birth	Date Signed

_____
Signature

Signed by: ☐ Patient ☐ Personal Representative of the patient

Personal Representative of the patient – *describe the legal authority that permits the representation:*

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