optima DENTAL CARE

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Patient Consent for Use and Disclosure of Protected Health Information
Professional to Professional

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Scott Johnson's 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. Dr. Scott Johnson Family and Cosmetic Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Scott Johnson Family and Cosmetic Dentistry at 1296 E. Polston Ave. Ste. A., Post Falls, Idaho, 83854.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry 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.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry may 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.

With my consent, Dr. Scott Johnson Family and Cosmetic Dentistry 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 Dr. Scott Johnson Family and Cosmetic Dentistry restrict how it uses or discloses 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 Dr. Scott Johnson Family and Cosmetic Dentistry's 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, Dr. Scott Johnson Family and Cosmetic Dentistry may decline to provide treatment to me.

Signature: _____ Date: _____

Patient / Parent or Legal Guardian