

# Patient consent form

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## **Fremont Family Dentistry**

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### **Patient Consent for Use and Disclosure of Protected Health Information**

10 I hereby give my consent for **Fremont Family Dentistry** to use and disclose  
protected health information (PHI) about me to carry out treatment, payment  
and health care operations (TPO).

(The Notice of Privacy Practices provided by **Fremont Family Dentistry**  
describes such uses and disclosures more completely.)

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I have the right to review the Notice of Privacy Practices prior to signing this consent.  
**Fremont Family 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 Mahvash Khajavi-Harvey Fremont Family Dentistry, 4464**  
20 **Fremont Ave N. Seattle, WA 98103]**.

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With this consent, **Fremont Family Dentistry** may call my home or other alternative  
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 calls pertaining to my clinical care, including laboratory test results, among others.

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With this consent, **Fremont Family Dentistry** may mail to my home or other  
alternative location 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."

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With this consent, **Fremont Family Dentistry** may e-mail to my home or other  
alternative 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  
**Fremont Family Dentistry** restrict how it uses or discloses my PHI to carry out TPO.  
The practice is not required to agree to my requested restrictions, but if it does, it is bound  
by this agreement.

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By signing this form, I am consenting to allow **Fremont Family Dentistry** to use and  
disclose my PHI to carry out TPO. I also acknowledge that I have been given the  
opportunity to review the Notice of Privacy Policies for Fremont Family Dentistry.

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, or later revoke it, **Fremont Family Dentistry** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient's Name

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Date

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Print Name of Patient or Legal Guardian, if applicable

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