**HIPAA Notice and Acknowledgment of Privacy Practices**
**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent for **Sweet Smiles** 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 **Sweet Smiles** describes such uses and disclosures more completely.)

I have the right to review and have reviewed the Notice of Privacy Practices prior to signing this consent. **Sweet Smiles** 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

**Sweet Smiles**
**365 Pearson Drive**
**Ste. 2**
**Porterville, CA 93257**
**(559) 788-2532**

With this consent, **Sweet Smiles** 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. Your medical history, treatment records, x-rays and any other material relevant to your treatment will be kept here. Your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. We may also use parts of your health information for research purposes, in study groups or at seminars as this may provide benefit to other patients. Should that happen, your personal identity will not be disclosed without your consent to do so. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

With this consent, **Sweet Smiles** 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." You may inspect or request copies of our records of your treatment at any time. Fees may apply. If any information we have about you is inaccurate, you may ask us to alter our records accordingly.

With this consent, **Sweet Smiles** 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 **Sweet Smiles** 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.

By signing this form, I am consenting to allow **Sweet Smiles** to use and disclose 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, or later revoke it, **Sweet Smiles** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable