G. Robert Marye, DDS, PA

Smiles of Texas A Family Practice

Acknowledgement of Receipt of Notice of Privacy Patient Health Information

I (Please print full name) _____, I understand that as part of my health care, Smiles of Texas originates and maintains paper and /or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care. I understand that this information serves as:

- A basis for planning my health care and treatment.
- A source of information for applying diagnosis and care unto the bill.
- A means by which a third party payer can verify that services charged were actually provided, and a tool for routine health care such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent, and the right to request restrictions concerning the disclosure of my health information for the purpose of treatment, payment or other related health care needs.

I understand that Smiles of Texas is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or by revoking this consent, this organization may refuse to treat me as permitted by section 164.520 of the Code of Federal Regulations.

I further understand that Smiles of Texas reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Smiles of Texas change the notice, they will provide a copy of the new notice to me at a subsequent visit.

I wish to add the following restrictions to the use or disclosure of my health information.

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I understand that as part of this organization's treatment, payment or health care operation, it may become necessary to disclose my protected health information to another covered entity, and I consent to such disclosure for these permitted uses including disclosure by electronic transmission, fax transmittal, internet and e-mail. I fully understand and accept the terms of this consent.

_____ _____

Signature of Patient / Legal Guardian Relationship to Patient

_____

Date

_____ No, I do not accept this consent.

Consent refused by patient / Legal Guardian and treatment refused as permitted.

01/01/2011