Consent for Purposes of Treatment, Payment, & Healthcare

I consent to the use or disclosure of my protected health information by Michael Holesh DDS for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct the healthcare operations of Michael Holesh DDS. I understand that diagnosis or treatment of me by Michael Holesh DDS may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Michael Holesh DDS is not required to agree to the restriction that I may request. However, if Michael Holesh DDS agrees to a restriction that I request, the restriction is binding on Michael Holesh DDS.

I have the right to revoke this consent, in writing, at any time, except to the extent that Michael Holesh DDS has taken action in reliance on this consent.

My “protected health information” mean health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Notice of Privacy Practices of Michael Holesh DDS prior to signing this document.

Michael Holesh DDS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

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Signature of patient or personal representative

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Name of patient

______________________________________________

Date

______________________________________________

Description of personal representative’s authority