CAPTIOL PERIODONTAL GROUP

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With your consent, Capitol Periodontal Group may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to CAPITOL PERIODONTAL GROUP'S Notice of Privacy Practices for a complete description of such uses and disclosures.

You have the right to review the Notice of Privacy Practices prior to signing this consent at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CAPITOL PERIODONTAL GROUP, ATTN: PRIVACY OFFICER, 1810 Professional Dr. Sacramento, Calif. 95825.

With your consent, CAPITOL PERIODONTAL GROUP may use or disclose your health information to a dentist, physician, or other health care provider providing treatment to you.

CAPITOL PERIODONTAL GROUP may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

CAPITOL PERIODONTAL GROUP may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using your professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. WE will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pickup filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

With your consent, CAPITOL PERIODONTAL GROUP may call your 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 your clinical care, including laboratory results among others.

With your consent, CAPITOL PERIODONTAL GROUP may mail to your home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

You have the right to request that CAPITOL PERIODONTAL GROUP restrict how it uses or discloses your PHI. However, the practice is not required to agree to your requested restrictions, but if it does, it is bound by this agreement.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in relevance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE:

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.