# Matthew A. Pollard, D.D.S.

## Consent for Use & Disclosure of Personal Health Information

My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have been given the opportunity to review and receive a copy of Pollard Dental's Notice of Privacy Policies, which explains my rights. I also understand that Pollard Dental has the right to change their Notice of Privacy Policies. I may request a current copy of their Notice of Privacy Policies at any time.

*My signature also authorizes Pollard Dental to use my PHI for the purposes of healthcare, treatment, and payment activities.*

______________________________________________

Signature Date

______________________________________________

Printed Name

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

______________________________________________

Personal Representative's Name Relationship to Patient

My signature also covers the following dependents under the age of 18 that are on my account at Pollard Dental:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

You may disclose my personal health information to the following individuals:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Annual Updates

______________________________________________

Signature Date

______________________________________________

Signature Date

______________________________________________

Signature Date