Carolina Dental Alliance

Consent for Treatment

I give this practice, _____ , my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Signature:_____ Date: _____
(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient
_____