CENTREVILLE DENTAL ASSOCIATES, PC

Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a toll for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have right to review the notice prior to signing this consent. I understand that the Centreville dental associates, PC reserves the right to change their notice and practices, and prior to implementation will mail a copy of revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and the Centreville Dental Associates, PC is not required to agree to restriction requested, I understand that I may revoke this consent in writing, except to the extent that the Centreville Dental Associates, PC has already taken action in reliance thereon.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:
Office Manager
6019 Centreville Crest Lane
Centreville, VA 20121
PH: 703-226-2000
Fax: 703-830-8009

I request the following restriction to the use or disclosure of my health information:
_____
_____
_____
___

_____ Accepted _____Denied Signature: _____

Name: _____ Date: _____ Relationship to Patient_____
Address: _____