PATIENT CONSENT FORM

Patient consent for Use/Disclosure of Health Care Information

Patient's name: _____

I understand that the patient's health information is private and confidential. I understand that Southern Smiles, LLC. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Southern Smiles, LLC. may use and disclose the patient's personal health information to help provide health care to the patient, handle insurance billing and take care of other health related needs. In general, there will be no other use and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Southern Smiles LLC. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

The most current "Notice of Privacy Practices" may be provided to me upon request.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Southern Smiles LLC. can give me called "The Revocation of Consent for Use and Disclosure of Health Care Information".

2. Writing, signing and dating a letter to Southern Smiles, LLC. that states that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment and other health care related needs.

If I revoke this consent, Southern Smiles, LLC. does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Southern Smiles, LLC. "Notice of Privacy Practices". My signature means that I agree to allow Southern Smiles, LLC. to use and disclose the patient's personal health information to carry out treatment, payment and dental operations.

_____ _____

Patient or Legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal rep, etc.)