

MICHAEL D. DOYLE D.D.S., LLC

PRACTICE LIMITED TO ENDODONTICS

PATIENT CONSENT / ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Michael D. Doyle, DDS, LLC, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this dental specialty office at (478) 971-1228 and requesting a revised Notice. We will also post any revised notice in the waiting room.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF *OUR NOTICE OF PRIVACY PRACTICES* OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name _____ Date _____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT / **ACKNOWLEDGEMENT** OF NOTICE OF PRIVACY.

All forms are for educational use only and do not constitute legal advice. All forms are subject to changes in the federal law and applicable state laws.
Seek legal advice before use if needed.