



**FLORIDA
DENTURE
INSTITUTE**

A reason to smile again.

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Florida Denture Institute may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With my consent, Florida Denture Institute may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. Including laboratory results among others.

With my consent, Florida Denture Institute may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Florida denture Institute may e-mail to my home or designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Florida Denture Institute's use and disclosure of my PHI to carry out TPO. If I do not sign this consent, Florida Denture Institute may decline to provide treatment to me.

With my consent, Florida Denture Institute may disclose my PHI to carry out TPO to the following area(s):

Dentist Physician Legal Guardian Power of Attorney

Relative _____
Name

Other _____
Name

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Witness