Michael Crovatt, DMD

Patient Privacy Form

I consent to the use or disclosure of my protected health information by Michael Crovatt, DMD for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Michael Crovatt, DMD. I understand that diagnosis or treatment of me by Michael Crovatt, DMD referred to maybe conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health care information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Michael Crovatt, DMD is not required to agree to the restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, any time, except to the extent that Michael Crovatt, DMD has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Michael Crovatt, DMD’s “NOTICE OF PRIVACY PRACTICES” prior to signing this document. Michael Crovatt, DMD’s “NOTICE OF PRIVACY PRACTICES”HAS BEEN PROVIDED TO ME. The “NOTICE OF PRIVACY PRACTICES” describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Michael Crovatt, DMD. The “NOTICE OF PRIVACY PRACTICES” for Michael Crovatt, DMD is also available at the reception desk.

Michael Crovatt, DMD reserves the right to change the privacy pratices that are described in the “NOTICE OF PRIVACY PRACTICES”. I may obtain a revised notice of privacy practices by calling the office or requesting one at my next appointment.

Signature of Patient or Personal
Representative _____

Date_____

Print Name of Patient or Personal
Representative_____