CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I hereby authorize Dr. William Schlesinger, D.D.S., M.A.G.D., to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Schlesinger can refuse to treat me.

I have been informed that Dr. Schlesinger has prepared a notice which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Schlesinger in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Schlesinger took before receiving my revocation.

I understand that Dr. Schlesinger as reserved the right to change his privacy practices so that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Schlesinger restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Dr. Schlesinger does not have to agree to such restrictions, but that once such restrictions are agreed to Dr. Schlesinger must adhere to such restrictions.

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Signature of patient or patient's representative Date

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Printed name of patient or patient's representative

Relationship to patient

Self Parent Spouse/Domestic Partner Guardian Child Sibling Other