VILLANO Oral-Maxillofacial-Implant Surgery

JOHN E. VILLANO, D.D.S., P.C.
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CONSENT OF DISCLOSURE

I hereby give consent to John E. Villano DDS, PC and his healthcare staff within this facility to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations. These may include but are not limited to the following:

- ✓ Your referring doctor or dentist
- ✓ A doctor or dentist we may refer you to
- ✓ Your insurance company
- ✓ Your pharmacy
- ✓ An outside diagnostic laboratory
- ✓ Persons accompanying you and/or your ride source
- ✓ The on-call doctor when Dr. Villano is not available
- ✓ Voice mail or answering machine for appointment confirmation

This consent will remain in effect, unless a written *Consent of Disclosure Cancellation* is received. Your cancellation must be in writing and signed. You may obtain this document from our office. This may be delivered in person or by mail, but it will not be effective until which time it is received in this office. Your cancellation will not be retroactive to previous disclosures.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations.

Your signature below indicates that you have been presented with and read the above information and have received a copy of our NOTICE OF PRIVACY PRACTICES. We will make you a copy of this form at your request.

Print Name of the **Patient**: _____

Signature:_____Date:_____

If you are signing as the patient's representative (the patient is a minor or disabled):

Print your name:_____ Relationship:_____

Signature:_____Date:_____