MY Dentists
Drs, Michalski, Yeager and Pinnavaia
Consent For Use and Disclosure Of Health Information

Print Name _____ DOB: _____

PLEAE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice Of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare, operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice Of Privacy Practices; we will issue a revised Notice Of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice Of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager of Drs. Yeager, Michalski and Pinnavaia
Telephone: 704-375-8577 Fax: 704-331-9987
Address: 411 Billingsley Road, Suite 102 Charlotte, NC 28211

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: I have had full opportunity to read and consider the contents of this consent form and your Notice Of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Please list any persons you wish to have access to your account:(All areas of account will be accessible, unless documented below.)

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SIGNATURE _____ DATE _____

If not Patient, Print Name and Relation: _____

I revoke my consent for your use and disclosure of my protected health information for treatment payment activities and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I revoked my consent. I understand that revocation of my consent will prevent Drs. Yeager, Michalski and Pinnavaia from accepting assignment of my insurance benefits and will be unable to file those for me. The office will complete a receipt as treatment is completed for you to file with your insurance company.

SIGNATURE _____ DATE _____