Gordon R. Ediger, DDS

Parkway Plaza Dental
13450 Roe Avenue
Leawood, KS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Telephone: _____
Address: _____ City: _____ State: _____ Zip: _____

Section B: To the Patient – Please 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: The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required to maintain the privacy of our health information how it is used and disclosed.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, if we change our 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 anytime through designated contact personnel.

Contact personnel: Dr. Gordon R. Ediger or Char Ediger, Proprietors of Parkway Plaza Dental
13450 Roe Ave, Leawood, KS 66209
Telephone: 913-345-2929

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain, payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

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 healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

The completed Consent will be maintained in the patients record.
You are entitled to a copy of this Consent after you sign it.