KEVIN L. CARLTON, D.D.S., M.S., P.A.

PATIENT CONSENT FOR THE DISCLOSURE OF INFORMATION AND ACKNOWLEDGMENT FORM (HIPAA)

I understand that by signing this form I consent to the following:

1. Sharing information for the purpose of treatment:

   You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and educational/wellness programs specified by my insurance plan. This will include communication with our team in verbal and nonverbal form such as postcard reminders, recognition boards, sign in information, and forms of communication for patient care and office visits.

2. Sharing information for purposes of payment:
   You will share all necessary information with my insurer(s), governmental entities, and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process companies, and in extreme situations, credit bureaus or collection agencies.

3. Sharing of information for the purposes of operations:
   You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

I also understand that by signing this form, I give this office permission to leave messages on my answering machine or voicemail or with a relative regarding: notification of appointments, messages to call the office, test results, and any other information pertaining to your healthcare with Dr. Carlton.

Information may be left with _____ at my home or at another location. I understand that you will be unable to release ANY information to anyone other than the person/persons listed above.

My consent is freely given. I understand that I may revoke this consent at anytime if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____ _____

PATIENT'S NAME (PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) DATE

I have read and been offered/given a copy of the Notice of Privacy Practices for Kevin L. Carlton, D.D.S., M.S., P.A.

_____

Initials