

William Glover, III, DMD, LLC

Cosmetic & Implant Dentistry

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, William Glover, III, DMD, LLC may use & disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to William Glover, III, DMD, LLC's Notice of Privacy Practices for a more complete description of such uses & disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. William Glover, III, DMD, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to William Glover, III, DMD, LLC Privacy Officer at 1507 S. Hiawasse Rd, Suite 209, Orlando, FL 32835.

With my consent, William Glover, III, DMD, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, William Glover, III, DMD, LLC may mail to my home or any other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements.

With my consent, William Glover, III, DMD, LLC may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and statements. I have the right to request that William Glover, III, DMD, LLC restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to William Glover, III, DMD, LLC's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, William Glover, III, DMD, LLC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Patient's Name (if different from signature)

1507 S. Hiawasse Rd, Suite 209, Orlando, FL 32835
407-522-5595 * facsimile 407-522-5598