

Patel Medical and Dental Associates

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy.

As our patient we want you to know that we respect the privacy of your personal medical records and we will do all we can to secure and protect that privacy. When it is appropriate and necessary we may provide minimum necessary information to those are in need in order to provide health care that is in your best interest.

FOR TREATMENT: We may share your medical information about you to other health care providers to assist them in treating you. We may provide your personal information to laboratories.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on bill may include your personal health information.

FOR HEALTH CARE OPERATIONS: We may use your medical information for measuring and improving quality and evaluating the performance of our practice. We may call you at the phone numbers you have provided regarding appointments or further treatment or lab results and may leave message on the machine or with the person answering the phone.

We also want you to know that we support your full access to personal health records. You may refuse to consent to the use or disclosure of personal health information (PHI) but this must be in writing. Under this law we may have right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse to consent to all or part of PHI and this must be in writing. You may not revoke actions that have already been taken when relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature _____ Date _____

Print Name _____