Southwest
Dental Associates

Helen H. Harless, D.D.S., F.A.G.D.

Patient Consent

Name _____ Birth Date _____/_____/_____

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

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

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been give the right to review such *Notices of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed in treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

Please print, sign, and date. If you have completed this form for another person, please print your name and sign below along with your relationship to the patient named above.

Print _____ Relationship _____

Signed _____ Date _____

Photo Release

I hereby authorize Southwest Dental Associates to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines, etc.).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept strictly confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Please print, sign, and date. If you have completed this form for another person, please print your name and sign below along with your relationship to the patient named above.

Print _____ Relationship _____

Signed _____ Date _____