564 N Lincoln Ave
Loveland, CO 80537

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info@lincolnplacedentistry.com

HIPAA Consent for Confirming Appointments

Patient Consent for Use and Disclosure of Protected Health Information.

With my consent, designated Lincoln Place Dentistry personnel may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Lincoln Place Dentistry's Notice of Privacy Practices for a complete description of such uses and disclosures.

I fully understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Lincoln Place Dentistry reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Chief Officer, Todd Minehart, Lincoln Place Dentistry, 564 N. Lincoln Ave, Loveland, CO 80537.

With my consent, Lincoln Place Dentistry may call my home or other designated location and leave a message on voicemail or in person in reference to any actions that assists Lincoln Place Dentistry personnel in carrying out TPO, such as appointment confirmations, insurance items and any call pertaining to clinical care.

With my consent, Lincoln Place Dentistry personnel may mail to my home or other location any items that will assist in carrying out Treatment, Payment, and Healthcare Operations (TPO), such as an appointment confirmation card, and patient statements.

With my consent, Lincoln Place Dentistry personnel may e-mail to my home or other designated location any items that assist Lincoln Place Dentistry in carrying out TPO, such as appointment confirmations and patient statements. I have the right to request that Lincoln Place Dentistry restrict how it uses or discloses my PHI to carry out TPO; however, Lincoln Place Dentistry 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 Lincoln Place Dentistry's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that Lincoln Place Dentistry has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lincoln Place Dentistry may decline to provide treatment to me, forward insurance claims on my behalf, or provide protected PHI to sources outside of the Lincoln Place Dentistry organization.

______________________________	______________________
Signature of Patient or Legal Guardian	Relationship to Patient
______________________________	______________________
Patient's Name	Date
______________________________	
Print Name of Patient or Legal Guardian	