BAKER VICTORY SERVICES
Continuing Father Baker's Legacy of Caring

Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

Section A:

Client/Individual's Name:_____ Client/Individual's ID #:_____

I authorize the use and disclosure of my Protected Health Information by the Agency listed below and by the Agency's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Agency Using and Disclosing the Information:

Baker Victory Dental Center

Agency Address:
790 Ridge Road
Lackawanna, NY 14218

Section B. Important Information Regarding this Consent:

1. I understand New York laws require my consent before the Agency may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Agency to:

- ♦ plan my care and treatment;
- ♦ communicate among various health care professionals who are involved in my care or treatment;
- ♦ obtain payment for care provided by the Agency or for the payment activities of another health care provider or entity;
- ♦ provide information to my health insurance company or plan;
- ♦ obtain payment from my health insurance company or plan; and
- ♦ assess and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Agency and that the Agency may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Agency's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Agency's Notice of Privacy Practices.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Client/Individual or Personal Representative:_____

Print Name of Client/Individual or Personal Representative:_____

Description of Personal Representative's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____

_____

_____

Telephone: _____(Daytime) _____(Evening)

For Agency Use Only

For Agency Use Only.

Date Agency Obtained Consent:_____

Name and Title of Person Obtaining Consent:_____

Action Taken by Agency on Consent:_____

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