

KARL A SMITH DDS LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for KARL A SMITH DDS LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). KARL A SMITH DDS LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. KARL A SMITH DDS LLC 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 Privacy Officer at 2500 N Van Dorn Street, Suite 128, Alexandria, VA 22302.

With this consent, KARL A SMITH DDS LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, KARL A SMITH DDS LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient billing statements.

With this consent, KARL A SMITH DDS LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that KARL A SMITH DDS LLC restrict how it uses or discloses my PHI to carry out TPO. 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 the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I understand that 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, or later revoke it, KARL A SMITH DDS LLC may decline to provide treatment to me.

Signature of patient or legal guardian

Date signed

Printed name of patient and/or legal guardian