Consent for Disclosure of Health Care Information

Patient's Name:_____ Date of Birth:_____

SSN:_____ Previous name:_____

Dr. Frederick L. Steinbeck, DDS MD
627 Highland Avenue
Fort Thomas, KY 41075

My personal health information is private and confidential. I understand that Dr. Steinbeck and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that Dr. Steinbeck and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask Dr. Steinbeck to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Dr. Steinbeck does not have to agree to my request. If Dr. Steinbeck does not agree to my request, I understand that Dr. Steinbeck and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1.) Signing and dating a form that Dr. Steinbeck and his staff can give me called "Revocation of Consent for Use and Disclosure of Health Information"; or

2.) Writing, signing, and dating a letter to Dr. Steinbeck directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, Dr. Steinbeck and staff do not have to provide any further health care services to me.

Dr. Steinbeck has a detailed document called the "Notice of Privacy Practices". It contains information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. Dr. Steinbeck may update this "Notice". If I ask, Dr. Steinbeck and his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at Dr. Steinbeck's office.

My signature below indicates that I have been given the chance to review a current copy of Dr. Steinbeck's "Notice of Privacy Practices". My signature means that I agree to allow Dr. Steinbeck to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient (or legally authorized individual) signature Date

Relationship to Patient (Parent, Legal Guardian, etc.)