PATIENT CONSENT AND ACKNOWLEDGMENT FORM
FOR
DENTAL ARTS OF CORINTH, PLLC

EDWARD S. KNIGHT, DDS **MARK R. MAZURKIEWICZ, DMD**

C. WILLIAM BAILEY, DMD TIFFANY T. HOLLINGSWORTH, DMD JACKIE S. McCLAIN, DDS

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights 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 health care providers who may be involved in that treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal health care operations such as quality assessments and physician referrals.

Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the privacy notice and sign this consent.

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

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

_____, specifically, has my written consent to call and make appointments for, discuss treatment plans with, and discuss account balances for _____. All other stipulations above apply.