# Dr. Stacy Johnson, DDS, MS

## Patient Consent For Use AND Disclosure Of Protected Health Information

I hereby give my consent for Dr. Stacy Johnson, DDS MS to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.(TPO) The Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Stacy Johnson, DDS MS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Stacy Johnson, DDS, MS. Attn: Front Desk, 3056 W. Stones Crossing Rd. Greenwood, IN 46143.

With this consent Dr. Stacy Johnson, DDS MS may call my home or other alternative location and leave a message on voicemail 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, including laboratory results among others.

With this consent, Dr. Stacy Johnson, DDS MS 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 statements as long as they are marked Personal and Confidential.

With this consent, Dr. Stacy Johnson, DDS MS may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request restriction of how it uses or discloses my PHI to carry out TPO.

However, 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 Dr. Stacy Johnson, DDS MS use and disclosure of PHI to carry out TPO.

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, Dr. Stacy Johnson DDS MS may decline to provide treatment to me.

## Receipt of Notice of Privacy Practice – Written Acknowledgement

I have received a copy of Dr. Stacy Johnson, DDS MS's Notice of Privacy Practices.

_____

Signature of Patient of Legal Guardian

_____ _____

Printed Name of Patient Date

**Information Can Be Released To:**

_____ _____

Name Relationship

_____ _____

Name Relationship

**WE DO NEED COPY OF THE POWER OF ATTORNEY FOR PATIENT CHART**