Drs. Stukalin, P.A.

Ronald S. Stukalin, D.D.S., M.S. Janet E. Stukalin, D.D.S.
5925 Forest Lane, Suite 318
Dallas, Texas 75230
(972) 490-4881

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NAME: _____BIRTHDATE:_____
If Minor, Parent/Guardian: _____
Address: _____
Telephone: Home: _____Cell:_____Fax:_____

To the patient/Guardian-PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This includes, but is not limited to, providing relevant information and records to your insurance company regarding verification and/or claims for your care and treatment, consulting with other doctors/healthcare providers with relevance to your care and treatment, and calling in any necessary prescriptions to your designated pharmacy pertaining to your care and treatment. Information will NOT be discussed with, or shared with any other entities/persons without your written permission. For those whom you have given us permission to discuss your treatment/information with, it will remain in effect until we have written and signed termination by you.

Additional person(s) authorized to release information to (via email, phone, text, or email):
Name: _____Phone: _____Relation: _____
Name: _____Phone: _____Relation: _____

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare 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 will be happy to supply you a copy of this notice upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised version of said notice containing the changes. These changes may apply to any of your protected health information that we maintain. You may obtain a copy of this notice by contacting:

Contact Person: Mary W. Phone: (972) 490-4881 Address: 5925 Forest Ln., Suite 318, Dallas, TX 75230

Right to Revoke: You have the right to revoke the HIPPA Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the HIPAA Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, (print name) _____, have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices of Drs. Stukalin, P.A. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations as deemed necessary by the staff of this office.

Please fill out this portion ONLY if you want to be contacted by Email and/or Text

You have requested that our practice communicate with you electronically. By utilizing our practice's electronic services, you agree that Drs. Stukalin, P.A. may send you any information through the Internet to an email address you designate or by text messaging to a cell number you designate.

Consent and Acknowledgement:

I, (print name) _____, in the presence of my dentist and/or staff, agree that the practice may electronically communicate with me at the following email address: _____
And text message me at the following phone number: _____. I understand that this includes any and all of my financial information, medical information, personal information, and information regarding my treatment/dental visits. I am responsible for keeping all of my contact information updated with Drs. Stukalin, P.A.
I can withdraw my consent to electronic communications, at any time, by calling the contact person above.

Signature of Patient/Guardian: _____Today's Date: _____
Relationship to patient, if not the patient: _____