Todd P. Roth, DMD
Todd P. Roth, DMD, P.C.
Practice Limited to Endodontics

New patient consent for the use and disclosure of dental/medical records for treatment, payment, or dental care options.

I, _____ understand that as part of my dental care, Todd P. Roth DMD, P.C. originates and maintains paper and/or electronic records describing my health/dental history, symptoms, examination and test results, diagnoses, treatment, and any plans for future dental care treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health/dental professionals who contribute to my care,
A source of information for applying my diagnosis and treatment information to my bill,
A means by which a third-party payer can verify that services billed were actually provided and a tool for routine dental care operations such as assessing quality and reviewing the competence of dental care professionals.

I understand and have been provided with a NOTICE OF PRIVACY POLICIES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to request restrictions as to how my dental information may be used or disclosed to carry out treatment, payment or dental care options.

In addition to myself, I consent to the following adult individuals to have access to my dental records: (please give full name and address)

_____

_____

_____

I understand that Dr. Todd Roth is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Todd Roth reserves the right to change his notice and practices in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or dental care operations, it may become necessary to disclose my protected dental/health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient's Signature _____ Date _____
Parent or Guardian Signature _____ Date _____
FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted.