Dental Solutions of Central Arkansas, P.A.
David M. Reese D.D.S Greg Simon D.D.S.
607 Front Street Conway, AR 72032
(501) 327-2586 www.conwayarkansasdentist.com

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Dental Solutions of Central Arkansas, PA, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 501-327-2586 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMLENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name_____ Date _____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ ACKNOWLEDGMENT OF NOTCIE OF PRIVACY.

_____

_____

***Federal Law requires us to have a signed consent form for every patient. Parent or Guardian must sign for anyone under the age of 18.**

Dental Records Information Release Form

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
Spouse____ Children____ Parent____ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed:_____ Date____/____/_____