CONSENT AND AUTHORIZATION

MICHAEL K. SHINNERS, D.D.S., S.C.

I give this practice my consent to use or disclose my protected health information, including health records, HIV test results, and mental health records to carry out treatment, payment from insurance companies, and health care operations.

I have been provided with a copy of and have been informed that I may review the Notice of Privacy Practices before signing this Consent and Authorization. I have been advised to read this Consent and Authorization carefully and completely before signing it.

I understand this practice has the right to change its Privacy Practices and that I may obtain any revised Notices of its Privacy Practices.

I understand that I have the right to request restrictions on how the practice will use and disclose my protected health information for treatment, payment, and health care operations. However, I also understand that the practice is not required to agree to my request for restriction, but it is bound by any restriction to which it agrees. I also understand that I may request to receive confidential communications from the practice at either alternative locations or by alternative means, such as receiving a telephone call at my office rather than my home.

I understand that I have a right to revoke this Consent and Authorization at any time and may do so by submitting my request for revocation in writing to this practice. I understand that my revocation will not apply to information that has already been released and/or disclosed.

Signature: _____ Date: _____
Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient _____