

E. C. Tyree Health & Dental Clinic

Medical Release/ Notice of Privacy Practices Form

I give the E.C. Tyree Health & Dental Clinic my consent to use and disclose my protected health and dental information to carry out my treatment, to obtain payment from insurance companies, and for all other health care operations.

I have been informed that I may review the Health and Dental Clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that the Health and Dental Clinic has the right to change their privacy practices and that I may obtain a revised notice from the E.C. Tyree Health and Dental Clinic.

I understand that I have the right to request a restriction of how my protected Health and Dental information is used. However, I also understand that the Health and Dental Clinic is not required to agree to the request. If the Health and Dental Clinic agrees to my requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Signature: _____ Date _____
(Parent or legal guardian if under 18 years of age)

If signed by patient representative, state relationship to patient _____