MONTE R. TREDWAY D.M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED DENTAL HEALTH INFORMATION

With my consent, Dr. Monte Tredway D.M.D and his staff may use and disclose my protected dental health information (PHI) to carry out treatment, payment and dental care operations (TPO). Please refer to Dr. Tredway's NOTICE OF PRIVACY PRACTICES for a more complete description of such uses and disclosures.

I have the right to review the NOTICE OF PRIVACY PRACTICES prior to signing this consent. Dr. Tredway reserves the right to revise the Notice of Privacy Practices at anytime. A revised copy may be obtained from Dr. Tredway' Privacy Officer.

With my consent, Dr. Tredway and his staff may call my home or other designated location and leave a message on voicemail or in person regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, account balances, and any call pertaining to my dental care.

With my consent, Dr. Tredway and his staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and other dental care information.

I have the right to request that Dr. Tredway and his staff restrict how it uses or discloses my PHI. However, the practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Dr. Tredway and his staff to use and disclose of my PROTECTED DENTAL HEATH INFORMATION to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures per my prior consent.

If I do not sign the consent, Dr. Tredway may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

_____
Print Name of Legal Guardian

_____
Date

I have requested and received a copy of Dr Tredway's Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian