Nora Yousif, D.D.S.
Caro Dental Associates

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) AND ACKNOWLEDGMENT AND NOTICE OF PRIVACY PRACTICES

By signing this form, you are granting consent to **Nora Yousif, D.D.S.** to use and disclose your protected health information **(PHI)** for the purpose of treatment, payment and dental health care operations **(TPO)**. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this PHI. You have a legal right to review our information of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice you may obtain a copy of the revised notice by requesting it from our Privacy Official.

With my consent, **Nora Yousif, D.D.S.** may call my home or office and leave a message on a voicemail or in person, in reference to any items, and call pertaining to your clinical care, including laboratory results, among others. With my consent Nora Yousif, D.D.S may mail to my home or office any items that assist the practice into carrying out TPO such as appointment reminders and patient statements.

Please list any additional people whom we may share the patients treatment, scheduling and financial information with. Due to standards for Privacy of Individually Health Information ("Privacy Rule") any person not specifically named on this form will NOT be able to obtain any information.

Name:	Relationship to patient:
_____	_____
_____	_____
_____	_____

You have the right to revoke the consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent. If I decline to sign consent, **Nora Yousif, D.D.S**. may decline to provide treatment to me.

Signature: _____ Date: _____
(Patient or Guardian)

Print Patient's Name: _____

Print name of Legal Guardian: _____
(This consent has no expiration date)