

Patient Consent Form and FAX Privacy Waiver

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this contract. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Our office will communicate with you regarding your appointments in our office. Should you not be able to take our phone call, we will leave a message regarding the necessary information or request you to return our call regarding other pertinent information. Your signature will allow us to leave the above messages on an answering machine, voice mail or through another person.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Martin L. Kolinski, D.D.S., Ltd. of all liability. I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date