Rhode Island Endodontics
Usman Fazli, DMD
Diplomate, American Board of Endodontics
Fellow of Royal College of Dentists Canada

Consent for Use & Disclosure

PATIENT INFORMATION

First Name		Last Name		Birth Date	

AUTHORIZATION TO RELEASE INFORMATION

In compliance with federal law, it is the office policy of Usman Fazli, D.M.D., P.C. DBA Rhode Island Endodontics and office staff to not release confidential and/or unauthorized information. Whenever returning telephone calls and the answering machine picks up, we will leave a message if you permit. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Usman Fazli, D.M.D., P.C. DBA Rhode Island Endodontics and/or office staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

❑ Home telephone, answering machine ❑ Work telephone, voice mail ❑ Cell phone, voice mail, or text

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

You have the right to revoke this consent at any time by giving us written notice.

____
Name Relationship to Patient

____
Name Relationship to Patient

____
Name Relationship to Patient

I consent to such disclosure for these permitted uses, including disclosures via fax and email.

I authorize Usman Fazli, D.M.D., P.C. DBA Rhode Island Endodontics to release identifying health information under the following terms and conditions:

1. Care and services rendered at Rhode Island Endodontics including but not limited to progress notes, treatment plans, radiographs, treatment and follow-up care recommendations.
2. To the referring dentist(s): ____
3. To your dental insurance carrier in order to process any claims (if applicable).

HIPAA ACKNOWLEDGMENT

This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Please click on the hyperlink to obtain a copy: *Notice of Privacy Practices*

FORM COMPLETION

Signature of	❑ Patient ❑ Legal Guardian	❑ Parent ❑ Agent Under Durable Power of Attorney
Printed Name	*First Name*	*Last Name*

Signature of Patient, Parent or Guardian		Date	