WILLIAM J. HOLEVAS D.D.S., LTD
LIFE CHANGING DENTISTRY

Patient Consent Form

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 the consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

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 you prior consent.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Dr. William J. Holevas D.D.S., Ltd. will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them and obtain copies. I understand that these images will be stored in a secure and confidential manner that will protect my privacy, and that they will be kept for the time period required by law. I also understand that images and video may be used for educating patients and marketing purposes and only after receiving verbal approval from you will we use such images and video that identifies you.

Patient Signature/Date

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