ENDODONTIC CENTER, P.C.
ASSIGNMENT OF BENEFITS AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES: With this form you have been provided with a copy of our Notice or Privacy Practices which provides a full description of how we will use and disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care purposes. This Notice also explains important rights you have regarding your health information. **Endodontic Center, P.C.** (hereinafter referred to as the "Practice") reserves the right to change its Privacy Notice at any time but you may always obtain a current copy upon request.

USE AND DISCLOSURE OF INFORMATION: As described on our Notice of Privacy Practices, we will use and disclosure your individually identifiable health information for a variety of treatment, payment and health care operations purposes. Such disclosure of your information may be made via mail, telephone, e-mail, and/or internet as may be necessary for the Practice to complete these purposes. If your health information contains any priviledged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

APPLICABLE TO MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related medical claim.

ASSIGNMENT OF BENEFITS: In consideration for services and treatment rendered, I hereby assign, transfer and set over onto the Practice all health insurance, worker's compensation and automobile insurance, third party payment or any other benefits of any nature whatsoever now due to and payable to me to include personal injury protection, medical payments, underinsured/uninsured benefits, and any other benefits, and any other coverage which becomes available to me. I hereby authorize the Practice to use and disclose my health information to seek such benefits and I direct my insurance company to make all payments I may be entitled to directly to the Practice.

RESTRICTIONS ON USES AND DISCLOSURES: As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and health care operations and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you in a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions here.

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I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I understand that I can contact the Practice Privacy Officer at (781)341-5300 if I have further questions or any complaints. I hereby release the Practice, its professionals, employees and agents, from all liability arising from the use and disclosure of my health information for treatment, payment and operations purposes. I understand that I may revoke this consent in writing except to the extent the Practice has already taken actions in reliance on it. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment. I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

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Patient/Guardian **Relationship** **Date** **Witness**

TO BE FILLED OUT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM PATIENT

On______________, I attempted to obtain a written acknowledgment of receipt of the Practice Notice Privacy Practices from the above named patient, but was unable to because:
Check the appropriate box:
( ) Patient declined to sign the Written Acknowledgment. ( ) Other (specify details) ___________________________

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By:____Date:___________________________
Name and Title of Employee