Canyon Creek Endodontics

Dr. David V. Christianson, D.D.S

Offices in Provo and Lehi UT

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, the office of David V. Christianson, DDS, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our offices Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of David V. Christianson, DDS reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the office of David V. Christianson, DDS at 3707 N. Canyon Rd., Ste 7-D Provo, UT 84604.

With my consent, the office of David V. Christianson, DDS, may call my home or either designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, Including laboratory results among others.

With my consent, the office of David V. Christianson, DDS, may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as patient statements. I have the right to request that the office of David V. Christianson, DDS restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the office of David V. Christianson, DDS use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the office of David V. Christianson, DDS, may decline to provide treatment to me.

Print name of Patient or Legal Guardian_____

Signature of Patient or Legal Guardian _____

Print Name of Patient _____

Date _____/_____/_____

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