**Consent for Purposes of Treatment, Payment, & Healthcare**

I consent to the use or disclosure of my protected health information by Perimeter Dental Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct the healthcare operations of Perimeter Dental Group. I understand that diagnosis or treatment of me by David G. Scurria, D.D.S may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Perimeter Dental Group is not required to agree to the restriction that I may request. However, if Perimeter Dental Group agrees to a restriction that I request, the restriction is binding on Perimeter Dental Group and David G. Scurria, D.D.S.

I have the right to revoke this consent, in writing, at any time, except to the extent that David G. Scurria, D.D.S. has taken action in reliance on this consent.

My "protected health information" mean health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Perimeter Dental Group's Notice of Privacy Practices prior to signing this document.

Perimeter Dental Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

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Signature of patient or personal representative

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Name of patient

_____

Date

_____

Description of personal representative's authority