LOUIS R. MARION, D.M.D., M.S., L.L.C.
PROSTHODONTICS: IMPLANT, RESTORATIVE, AND ESTHETIC DENTISTRY

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PHILADELPHIA, PENNSYLVANIA 19102-4314
(215) 732-5110 • FAX (215) 732-9938

Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, the practice of Louis R. Marion, D.M.D., M.S. L.L.C. may use and disclose my protected health information (PHI) to carry out treatment, payment activities, and healthcare operations (TPO). Please refer to this office's 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 Louis R. Marion, D.M.D., M.S., and L.L.C. reserves the right to change the privacy practices as described in Notice of Privacy Practices at anytime. If this office changes or revises privacy practices, the revised Notice of Privacy Practices will be available in the same manner as the original. The Notice of Privacy Practices, including any revisions, can be requested at any time by contacting:

Contact Officer:	Dr. Louis Marion HIPAA Officer
Telephone:	215-732-5110
Fax:	215-732-9938
Address:	1500 Locust Street, Suite 1416 Philadelphia, PA 19102-4314

I will have the right to revoke this Consent at any time by giving the Contact Officer written notice of my revocation. This revocation may not cover disclosures that the practice made in reliance upon my prior consent. I also have the right to request that this office restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If I do not sign this consent, the office may decline to treat me or to continue treating me if I revoke this Consent.

I, _ {print name}_____ _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ _____

Relationship to Patient: _____ _____