PATIENT CONSENT FORM

GUFFEE DENTAL ASSOCIATES
Dr. Byron Guffee D.M.D.
Dr. Alan Blanchard D.D.S.
105 Professional Court
Anderson, SC 29621

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you're not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

____ Do ____ Do not leave messages on answering machine, voicemail, with a spouse or other family member.
____ Do ____ Do not call me at home.
____ Do ____ Do not call me at work.
____ Do ____ Do not mail, fax, or give an office school excuse to my child or anyone bringing them in my place.

Patient Name: ______________________________
Signature: ______________________________
Relationship of Patient: ______________________________
Date: ______________________________