MICHAEL S. WALKER, D.D.S.

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Dr. Michael S. Walker, DDS, PC
Consent for use and Disclosure of Health Information

I,____, have been given or reviewed the posted copy of the Notice of Privacy Practices. I understand that my signature on this form gives my consent for my protected health information to be used for the purposes of: **TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.**

I also acknowledge with this consent, that the office of Dr. Michael Walker may call (leaving messages on voice mail, answering machines, e-mails, or in person) or mail to my home or other alternative location, any healthcare operations such as : **APPOINTMENT REMINDERS, INSURANCE ITEMS, PATIENT STATEMENTS, REQUESTS TO CONTACT THE OFFICE, INSTRUCTIONS, OR OTHER REPLIES AS REQUESTED BY THE PATIENT.**

Other than other healthcare providers deemed by Dr. Walker to be needed to consult on your case, persons to whom information may be disclosed:

To: ____(Spouse, ex-spouse, etc.)
____(Grandparent, child, etc.)-
____

I have the right to revoke this consent at any time by giving written notice. I understand that revocation of this Consent will not affect any action that was previously taken in reliance of this Consent. If I refuse this Consent, or later revoke it, Dr. Walker may decline to provide treatment to me.

SIGNATURE of
Patient/Parent/Guardian________________________________date______________

Witness____

(The office of Dr. Michael Walker reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice may be obtained by forwarding a written request to this office.)