C. Timothy Assey, D.M.D., P.A.
John C Assey, D.M.D.

Notice of Privacy Practices Consent

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 the right to review such *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 health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
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.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

Do we have your permission to:

Leave a message on your answering machine at home to confirm your appointment? { }Yes{ }No

Mail a postcard to your home address to remind you of a scheduled appointment? { }Yes{ }No

Leave a message at your place of employment to call our office? { }Yes{ }No

Discuss your medical condition with any member of the household? { }Yes{ }No

If yes, whom:_____Relationship_____