OKA FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and permission to disclose relevant information regarding appointment confirmation/scheduling, billing treatment directives and relevant dental business to family and/or household members.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, permission to disclose relevant information regarding appointment confirmation/scheduling, billing treatment directives and relevant dental business to family and/or household members, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting.

Contact person: Nettie Ehia
Telephone: 808-235-7500 Fax: 808-235-5095
Address: 45-943 Kamehameha Highway, Suite #201 Kaneohe, HI 96744

Signing this Consent form I give Dr. John Oka, and Dr. Susan Shiroma permission to do the following…
(Please initial)

Please Initial

_____Permission to leave voicemail/answering machine messages regarding appointment confirmation, treatment directives and/or pertinent dental business

_____Permission to speak with family members regarding appointment confirmation, treatment directives and/or pertinent dental business

_____Permission to provide relevant billing information and/or dental information to include all patients in household on one collective billing form.

_____Permission to text, phone call and or email reminders and confirmation for dental appointments, post-operative instructions and home healthcare instructions.

_____Consent to send dental claims electronically

_____Consent to consult Physician

I, 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 protect health information to carry out treatment payment actives, health operations and permission to disclose relevant information regarding appointment confirmation/scheduling, billing treatment directives and relevant dental business to family and/or household members.

Print:_____ Signature:_____

Date:_____ Email address: _____

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

Personal Representatives name: _____
Relationship to patient: _____

YOUR ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.