

Addendum for Established Patients

Release of Information for Treatment and Health Care Operations

Patient Name: _____

Date of Birth: _____

In addition to the prior Consent and Agreement for Treatment I previously signed, by signing this Addendum, I am consenting to the use and disclosure of my Protected Health Information (“PHI”) for treatment and Nova Southeastern University’s health care operations purposes for myself or for the patient/client for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Dental Clinics (“NSU”) will share patient/client PHI according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

NSU’s Notice of Privacy Practices provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at the Dental Clinics.

I acknowledge and agree that the PHI that may be disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient/client: (i) any psychiatric or psychological information related to treatment of physical and/or mental illness; (ii) any information regarding drug abuse, chemical dependency or alcohol abuse; or (iii) any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (“AIDS”); human immunodeficiency virus (“HIV”); Sexually Transmitted Disease(“STD”); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to county, state, or federal public health agencies, as required by law.

I understand that I have the right to request that NSU restrict how it uses or discloses the patient’s/client’s PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the patient/client.

I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents.

Signature of Patient/Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative’s Authority