TENNESSEE CENTERS FOR
LASER DENTISTRY

CONSENT AUTHORIZATION ACKNOWLEDGEMENT

I authorize Dr. Chad O. Edwards & Dr. Ryan Torti and Tennessee Centers for Laser Dentistry, hereafter referred to as "practice", to take necessary radiographs, study models, photos and other diagnostic aids as needed to make a thorough diagnosis.

I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics, sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

HIPAA: Consent for Use and Disclosure of Health Information:

(Notice of privacy practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, 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. Please read this Notice prior to signing this Consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made a revised Notice of Privacy Practices containing the modifications will be issued. These changed may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting us at 615-595-8070, 204 Miller Springs Court, Ste 200, Franklin, TN 37064.)

You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment on your behalf or that of your dependents if this Consent is revoked.

I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry our treatment, payment activities and health care operations.

I understand and acknowledge my rights as detailed in the Notice of Privacy Practices presented here. I understand and consent to my medical information being used as described here.

I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here:

Signature: _____ *Date of Signing:* _____

Name (please print): _____