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Consent of Treatment

I hereby give consent to the doctors at Platinum Dental Inc. to take radiographs, study models, or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I also authorize and consent the doctors to perform and employ any and all forms of treatment, medication, and therapy, which may be indicated in connection with my dental needs. I understand the use of anesthetic agents embodies a certain risk. You may obtain a copy of the “*Dental Material Fact Sheet*”.

Signature (Patient/Responsible Party)

Date

HIPAA Consent of Disclosure

(For the Usage and /or Disclosure of Protected Health Information accordingly to the Health Insurance Portability and Accountability Act of 1966 (HIPAA))

I hereby give consent to Platinum Dental Inc. and all health care providers furnishing care with Platinum Dental Inc. to use and disclose my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Our posted Privacy Policy Notice (in reception room) provides more detailed information about the usage and disclosure of your Protected Health Information. You have the right to review our posted Privacy Policy Notice before you sign this consent.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our posted Privacy Policy Notice. You may obtain a copy of the current posted Privacy Policy Notice upon request.

I understand that this consent shall remain in force so long as I am a patient of this practice.

Signature (Patient/Responsible Party)

Date

Patient Name (Print)