ALANA K. MACALIK
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Patient authorization for use and disclosure of protected health information

for purposes requested by the practice

I give Alana Macalik, DDS, PLLC my consent to use and/or disclose my protected health information (PHI) to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I understand that Alana Macalik, DDS, PLLC has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my PHI is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Signature:_____ **Date:** _____

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient:_____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office. You are entitled to a copy of this consent after you sign it.