JOHN J. SAHLANEY, D.M.D., M.D.S.
PRACTICE LIMITED TO ORTHODONTICS

South Hills Village,
Suite 205
Pittsburgh, PA 15241
(412) 833-3922

LIMITED CONSENT TO RELEASE OR USE HEALTH INFORMATION

PATIENT GIVING CONSENT:
Name: _____

Address: _____

Telephone: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

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, and healthcare operations.

I, _____, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. My consent is limited to the following. Please initial each that you consent to.

Sending Recalls _____

Sending and calling reminders of appointments _____

Call in prescriptions to pharmacy _____

Corresponding with my family dentist or appropriate specialist _____

Submitting and corresponding with my insurance company _____

Signature _____
Date: _____

If this Limited Consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative's
Name: _____
Relationship to Patient: _____

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Signature _____
Date: _____

If this Limited Consent is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative's
Name: _____
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