New Patient Notice of Privacy
And Disclosure of Health Information

I understand that as a part of my healthcare, The office of Harold B. Welch, D.M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I grant permission to view prescription history for external sources. I understand that as part of this organization's treatment, payment, and healthcare operations., it may become necessary to disclose my protected health information to another entity associated with my medical care. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Privacy Policy of The office of Harold B. Welch, D.M.D., P.A. is available in the office for my perusal. I may also request my own copy if I desire.

I fully understand and accept the terms of this consent.

Patient Name(print)_____ Date_____
Patient Signature_____
Parent or Authorized representative (if applicable)_____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife/husband, child, etc)
Name_____ Relation_____
Name_____ Relation_____
Name_____ Relation_____

May we leave a message on your answering machine of the following:
Upcoming scheduled appointments ☐ yes ☐ no
Normal laboratory/ pathology results ☐ yes ☐ no