

**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: _____

This transmission contains confidential and/or medically confidential information intended only for the use of the individual(s) named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance of the contents on this transmission is strictly prohibited. If you receive this communication in error, please call (412) 833-3922 so that we can arrange for return of the documents to us at no cost to you. Thank you.

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I, _____, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature _____

Date: _____

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