INDIVIDUAL PATIENT'S AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Absolute Dental participates in a network of healthcare providers that accept payment for dental and other healthcare services through CareCredit and other third-party financing service providers (collectively, "Credit Providers"). You may be eligible for financing or payment plan arrangements with one or more of Absolute Dental's affiliated Credit Providers. If you are interested to learn more about financing your dental care at Absolute Dental with credit, you must complete and sign this form. By doing so, you will authorize Absolute Dental to use or disclose certain protected health information about you to determine if you pre-qualify with one or more of Absolute Dental's affiliated Credit Providers.

1. INDIVIDUAL PATIENT CONFIRMING THE AUTHORIZATION

Please provide the following information. If you are completing this form on behalf of the patient whose protected health information is subject to this authorization, please provide the following information about the patient:

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Patient Account Number: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZATION

By signing this form, I voluntarily give my authorization to use or disclose my protected health information (PHI), subject to the following terms and conditions:

PHI Subject to This Authorization: I authorize Absolute Dental to use or disclose the following types of PHI for the purposes described in this form:

- My first, middle, and last name
- My address, including city, state, and zip code
- My phone number(s)
- My email address(es)
- My social security number

Who May Use, Disclose, or Receive My PHI: I authorize Absolute Dental to use or disclose my PHI for the purposes described in this form. I authorize Absolute Dental's affiliated Credit Providers and consumer reporting agencies to use PHI they receive from Absolute Dental for the purposes described in this form.

Purposes of the Use or Disclosure of My PHI: I authorize the use or disclosure of my PHI for the following purposes:

- To permit Absolute Dental, its affiliated Credit Providers, and their business associates to review my credit history to determine if I pre-qualify for financing or payment plan arrangements with any Credit Provider to pay for my dental care at Absolute Dental.
- To permit Absolute Dental and its business associates to send marketing communications to me about financing or payment plan arrangements with any Credit Provider with which I am determined to pre-qualify.

3. ENDING THE AUTHORIZATION

This authorization will end when I cease obtaining my dental care at Absolute Dental. I understand that I may revoke this authorization at any time by giving written notice to Absolute Dental's Privacy Officer. However, I understand that I may not revoke this authorization or any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

4. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that Absolute Dental does not condition my dental treatment on signing this authorization form. If I do not sign this form, I may continue to receive dental treatment at Absolute Dental without consequence or penalty.

5. POSSIBILITY OF REDISCLOSURE

Although federal privacy laws and regulations require Absolute Dental and its business associates to protect the privacy and security of my PHI, those laws and regulations may not prevent redisclosure of my PHI by other recipient(s) under this authorization or protect the privacy and security of my PHI if such redisclosure were to occur.

6. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form with the people and/or organizations named or described in this form. If I am someone other than the patient completing this form, I attest that I am the patient's personal representative and have the legal authority to sign this form on the patient's behalf and authorize the use or disclosure of the patient's PHI as described in this form. All information I have provided in this form is accurate and truthful to the best of my knowledge.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name:

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.