Kensington Valley Endodontics, PC

Consent for Use and Disclosure of Health Information

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. **Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dr. Erich Dittmar at this office location. **Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your 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 heath care operations.

Signature: _____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name (Please Print):_____Relationship to Patient:_____

Informed Consent for Root Canal Therapy

Endodontic (root canal) treatment is a procedure through which infected teeth may be saved. Root canal treatment works by removing bacteria and irritants from the hollow space inside the tooth, and by sealing off the inside of the tooth to prevent re-infection. Although root canal therapy has a very high success rate, it is a biological procedure and cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require **retreatment, additional surgery, or extraction.**

I understand the **alternatives** to root canal treatment are extraction of the involved tooth or postponement of root canal therapy. I realize that postponement of treatment may result in future loss of the tooth.

I understand the possible **risks** of root canal therapy, although rare, do exist, and include (but are not limited to) pain, infection, swelling, fever, changes in occlusion (bite), reaction to medications or anesthetics, nerve injury following local anesthesia, temporal mandibular (jaw) joint pain, difficulty opening and closing.

I understand the possible **complications** of root canal therapy, although rare, do exist, and include (but are not limited to) instrument breakage in the root canal, inability to negotiate canals due to prior treatment or calcification, perforation to the outside of the tooth, irreparable damage to the existing crown or restoration, and cracking or fracturing of the root or crown.

I understand that **medications** administered or prescribed for me may have risks and adverse reactions which may adversely impact my health. Some medications may cause nausea, vomiting, allergic reactions, drowsiness, and impairment of motor and cognitive skills. Use of other drugs or alcohol along with some prescribed medications may result in detrimental side effects or interactions. Do not operate any vehicle or hazardous device when under the effects of some prescribed medications. Antibiotics may affect the effectiveness of birth control pills; alternative precautions should be utilized.

I understand that permanent **restoration** of my endodontically treated tooth is necessary within **6 weeks** of the completion of my endodontic treatment. I realize that this is my responsibility, and failure to have the permanent restoration placed by a dentist may lead to failure of the root canal treatment. I understand that it is not within the domain of my endodontist to perform this service.

All my questions have been answered, and I have carefully read and understand the above information. I give my consent for the procedure.

Signature of patient or guardian_____ Signature of Doctor_____

Date_____ Date_____