



Kennett Medical Center  
 402 McFarlan Road  
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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN AT THE BOTTOM OF PAGE.

**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 health information, and of our other important matters about your protected health information. A copy of our notice accompanies this consent upon request. 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.

**RIGHT TO REVOKE:** You will have the right to revoke this consent at any time by giving us written notice of your revocation, and that we may decline to treat you or to continue to treating you if you revoke this consent.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** We will gladly furnish you with a set of our Privacy Notice upon request at any time. The Privacy Notice is also displayed on our lobby wall at all times in plain view of our patients. If at any time you have questions or concerns regarding this Law, please feel free to ask us.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
 PRINT NAME: \_\_\_\_\_

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Family Members I give permission to release information to:

- 1) \_\_\_\_\_ Relationship \_\_\_\_\_
- 2) \_\_\_\_\_ Relationship \_\_\_\_\_