

**CONSENT FOR USE OR DISCLOSURE OF INFORMATION  
FOR PURPOSES REQUESTED BY  
VALLEY DENTL GROUP**

I hereby permit Valley Dental group to use my health information, and/or to disclose my health information to any third party payor, or to any party involved in my health care.

I understand that there is a Notice of Privacy Practices posted in the office available for me to read.

This consent shall be in force and effect as long as I am a patient in this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my doctor(s) at this practice.

I understand that information used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- \* Refuse to sign this consent form.

---

Signature of patient or personal representative  
Date

---

Name of patient or personal representative (Please Print)

---

Description of personal representative's authority.