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Family Dentistry

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Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: I have the right to review this facility's Notice of Privacy Practices prior to signing this form. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your health information.

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: I have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office. 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 continue treating you if you revoke this Consent. This Consent remains in effect until revoked.

Authorization of Use and Disclosure of Protected Health Information: The following persons are authorized to receive my protected health information:

_____

_____

I, **X**_____, have had full opportunity to read and consider the contents of this Consent form and the 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 operations.

Signature: **X**_____Date:**X** _____

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

Personal Representative:_____Relationship:_____