



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: To the Patient- Please read the following statements carefully

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 share your privacy practices as described in our Notice of Privacy Practices. If we change our policy, we will issue a revised Notice of Privacy Practices, which contain the changes. The 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 a revision of our Notice, by contacting our office manager: Karen Johnston. Her e-mail address is karen@hulenfamilydentistry.com

Right to Revoke: You 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 this revocation, and that we may decline to treat you or continue treating you if you revoke this consent

Section B: Signature

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 health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart.

For Office Use Only

If the patient declines to sign this form please check this box here:



PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner. *(Check and fill in all that apply):*

Work Telephone: _____

- O.K. to leave message with detailed information
- Leave a message with call back number only

Home Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call back number only

Cell Phone: _____

- O.K. to leave message with detailed information
- Leave message with call back number only

Written Communication

- O.K. to **e-mail** me at this address: _____ @ _____
- O.K. to mail to my home address
- O.K. to mail to my workplace
- O.K. to fax to this number: _____