Main Street Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Minor children this consent covers: _____

Social Security #: _____

Section B: 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.

Notices of privacy Practices: You have the right to read our Notice of Privacy Practices. 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 other important matters about your protected 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 we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, either by phone or in writing. Written requests may be mailed to: Privacy Officer, 712 W. Main St. Plainfield, IN 46168. Questions or concerns may also be telephoned to the privacy officer at (317) 839-5500.

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 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent from 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 and listed family members' protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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

Representatives Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.