

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: ADULT PATIENT OR PARENT OF MINOR GIVING CONSENT:

Name: _____

Address: _____

Telephone: (____) _____ Email: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of consent: By signing this form, you will consent our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and contact with your general dentist.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice 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 deserve the right to change our Privacy Practice as described in our Notice 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact: Office Management Telephone: (425) 744 – 1124 Fax: (425) 744 – 7813
Address: 16006 Ash Way, Suite 102, Lynnwood, WA 98087 Email: helpdesk@drjennifermeader.com

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 Office Management, as listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

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

Personal Representative's Name: _____

Relationship to patient: _____

REVOCACTION OF CONSENT:

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____