

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 is available upon request.

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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Privacy Officer at our office.

Consent for Treatment: I have provided my medical history to the best of my knowledge and answered all medical questions accurately. I understand that providing incorrect information can be dangerous to my health.

Consent for Insurance: I authorize and request my insurance company to pay directly to the dentist and any dental benefits otherwise payable to me. I understand that my insurance may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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 read and consider the contents of this Consent form and Notice of Privacy Practices. I understand by signing this Consent, 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.

Patient/Guardian Signature _____

Date: _____