Fletcher Heights Dental Care, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name:____Telephone:_________________________

Email:____

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Notice provides a description of our treatment, payment activities and healthcare operations, of the uses of disclosures we may make of your protected health information. A copy of our Notice is available upon request. We do encourage you to read it carefully and completely.

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:

Contact Person: Nancy Surkala
Telephone: 623-825-7833
Address: 8272 W. Lake Pleasant Pkwy, Ste 204 Peoria, AZ 85382

Right to revoke: You will have the right to revoke this Consent at any time by giving us a 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 to this Consent before we received your revocation, and 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 and 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 disclosures 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:____