

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

\*\*\*\*\*

Patient Name: \_\_\_\_\_

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights. We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. You can be confident that your protected health information will never be improperly disclosed or released. We only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. We may use and/or disclose your health information to communicate reminders about your appointments, including voicemail messages and post cards. A copy of our Notice of Privacy Practices, including any revisions of our Notice, may be obtained at any time by contacting our office at (719) 593-8488. You also have a right to get copies of your healthcare information, for a fee, and the right to revoke this consent at anytime, in writing. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Human Services.

\*\*\*\*\*

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. Including, but not limited to, relaying information regarding treatment and appointments to family members and co-workers, leaving voice mail messages on home, work, or cell phones, mailing of birthday and appointment reminder post cards, etc. My protected health information will NOT be used for marketing purposes without first obtaining separate, explicit written permission from you to do so.

List any exceptions relating to disclosure of information : \_\_\_\_\_

Signature of Patient OR Responsible party : \_\_\_\_\_

Relationship to patient : \_\_\_\_\_ Date : \_\_\_\_\_

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

**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 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 your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare 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 : \_\_\_\_\_