Brentwood Dental Center

Consent for Use and Disclosure of Health Information (HIPAA)

Section A:

Patient Giving Consent/ Name of Patient:

_____ (PRINT)

Section B:

PATIENTS, 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 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. A copy of our Notice is available at your request in our office. We encourage you to request a copy and read it carefully and completely before signing this consent. 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 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 Brentwood Dental Center.

Right to Revoke: You will have the right to revoke this Consent at any time by providing our office with 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 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.

Consent: I, the patient and/or representative*, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to 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, please complete the following:

_____ Personal Representative Name

_____ Relationship to Patient

*If there are any person (s) with whom you would like to share the patient dental information with please provide their information below:

_____ Name (s) Relationship to Self/ Patient