



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE PRINT

Patient Name

Responsible Party/Parent Name

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your/your child's protected health information to carry out treatment (radiographs, diagnostic records and any active treatment that is necessary), 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/your child's protected health information. A copy of our Notice is available for you to review and/or keep for your records. We encourage you to 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 Practices, which will contain the changes. Those changes may apply to any of your/your child's 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 requesting a copy from the Clinical Supervisor, Cheryl Mize.

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/your child or to continue treating you/your child 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/my child's protected health information to carry out treatment, payment activities and health care operations.

Signature

Date

Richard R. Woehrle, DDS, MS

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