Consent For Use and Disclosure of Health Information

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. Out Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matter about your protected health information. A copy of our Notice is available upon request. 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 Notice, 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, at any time by contacting our office.
Right to Revoke: You will have the right to revoke this Consent at any time giving us written notice of your revocation submitted to our office. 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 continue to treat you if you revoke this Consent.

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 protected health information to carry out treatment, payment, 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's Name: ___________________________________
Relationship to Patient: ____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _________________________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ____
Date:_____________________

Assignment and Release

I hereby authorize payment directly to **A Country Dentist** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or my dependents. I authorize **A Country Dentist** and it's employees to release the information required to secure payment of benefits. I authorize the use of this signature on all submissions.

I also authorize any employee of **A Country Dentist** to release required information to any dental specialists or other health care professional involved in or consulting on my treatment.

Signature: ____
Date:________________________