CHARLESTON FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT or REPRESENTATIVE GIVING CONSENT

Name: _____

If a personal representative or parent is signing this Consent on behalf of the patient, complete the following:

Representative's Name:_____ Relationship to Patient:_____

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 your dental treatment, payment activities such as insurance billing and collections, 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 protected health information. A copy of our Notice for your personal records will be provided if requested. We encourage you to read our notice 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 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 this office: Charleston Family Dentistry: Guerry Kirkland, office manager, 843-571-0117 or 2170 Savannah Hwy. Charleston, SC 29414.

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.

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 protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

Include completed Consent in the patient's chart.

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practice, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited sufficient understanding

_____Emergency situation

_____Other/ Specify Reason _____

_____No Parent or Guardian