

FAMILY DENTIST TREE

**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

SECTION A: PATIENT, PARENT/GUARDIAN (if under 18), OR PERSONAL REPRESENTATIVE GIVING CONSENT

Patient Name: _____

Parent/Guardian or Personal Representative if applicable: _____

SECTION B: CONSENT - PLEASE READ THE FOLLOWING CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care 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 health care 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 is available upon request, located on our website at www.familydentisttree.com, and is also located in our reception area. 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 containing the changes, and post the labeled revised copy in our reception area. 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: Kimberly Heimer
1011 Bel Air Lane NW, Rochester, MN 55901
Phone: (507) 288-1188 Fax: (507) 529-4065

Right to Revoke: You 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 of 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.

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 protected health information for the patient name listed in Section A 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, complete the following:

Relationship to Patient: _____

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

Include completed Consent in the patient's chart.