CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: ***Patient Giving Consent***

Name: _____ SSN: _____

Address: _____

Telephone: _____ Email: _____

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 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. 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 accompanies this Consent. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dr. Patrice Barber, DDS
Alliance Family Dental
5428 Yadkin Road, Fayetteville, NC 28303
Telephone: (910) 868-4664, Fax: (910) 868-4949
Email: office@alliancefamilydental.com

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 affect any action we took in reliance of this consent prior to receiving your revocation. As a result, we may decline to treat you or to continue treating you if you revoke this consent.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and to the parties described below.

Description of the specific information to be used or disclosed:

_____
_

_____
_

_____
_

Person or entity who may receive the specific information disclosed:_____

_____
_

Signature: _____ Date: _____

If this consent is signed by a personal representative of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____