HOPE FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security #: _____

Address:_____

Telephone: _____ E-mail:_____

Patient Chart #:. _____

SECTION B: TO THE PATIENT---PLEASE READ THE FOLLOWING STATEMENT 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 brotected health information, and of the important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completed 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 practice, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of you protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practice, including any revision of our Notice, at any time by contacting us at:

Hope Family Dentistry.
17185 Arrow Blvd
Fontana, Ca 92335
Phone (909) 587-2474 Fax (909)356-4358

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 office list 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 consent form and your Notice Of Privacy Practice, 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 healthcare operations.

Signature_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relation to the Patent: _____