VINA COMMUNITY DENTAL CENTER

"THE HEART OF LIVINGSTON COUNTY DENTISTRY"

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND TREATMENT

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By printing or 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. An automated prescription record may be run at any time at the discretion of the treating dentist.

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. 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. Those changes may apply to any of your protected health information that we maintain.

I, ______________________________________ (Print name) 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 health care operations.

SIGNATURE
Signature: ____ Date: _____________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____________________________________ Relationship to Patient: ______________________

I consent the release of my protected information over the telephone to the following individuals:

Name of person: _______________________________________ Relationship: _______________________
Phone Number: ____ Alternate Phone: ____________________

Name of person: _______________________________________ Relationship: _______________________
Phone Number: ____ Alternate Phone: ____________________

I understand that the information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and no longer protected by HIPAA. I also understand that this consent will remain in effect until revoked in writing.

Signature: ____ Date: _____________________________